Parliamentary and Health Service Ombudsman

Selected summaries of investigations by the Parliamentary and Health Service Ombudsman

April to June 2014

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Parliamentary and Health Service Ombudsman

Selected summaries of investigations by the Parliamentary and Health Service Ombudsman

April to June 2014

Presented to Parliament pursuant to Section 14(4)
of the Health Service Commissioners Act 1993

Presented to Parliament pursuant to Section 10(4)
of the Parliamentary Commissioner Act 1967

Ordered by
the House of Commons
to be printed on 28 October 2014

HC 744

Any enquiries regarding this publication should be sent to us at phso.enquiries@ombudsman.org.uk.

This publication is available at https://www.gov.uk/government/publications

Print ISBN 9781474111553

Web ISBN 9781474111560

Printed in the UK for the Williams Lea Group on behalf of the
Controller of Her Majesty's Stationery Office

ID P002680195 10/14

Printed on paper containing 75% recycled fibre content minimum

Contents

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

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 second 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.

October 2014

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Parliamentary cases

Summary 83/April 2014

Criminal Records Bureau's service was not adequate

Delay and poor handling resulted in distress and lost earnings.

What happened

The Criminal Records Bureau (CRB) – now the Disclosure and Barring Service – took 36 weeks to return Mr M's record check because of many errors. Mr M applied for the record check so that his wife could begin home childminding.

Specifically, the CRB failed to identify Mr M's record with an exact match on the Police National Computer, causing delay as it then asked him to take a fingerprint test and complete a true likeness check. It also handled Mr M's redress claim poorly by delaying its investigation by eight weeks and not telling him about progress. And it wrongly implied in a letter that people matched to records on the Police National Computer had criminal records, when, in Mr M's case, his entry was purely for information.

Although he was largely satisfied with the findings and recommendations of the CRB's Independent Complaints Monitor (ICM), Mr M complained that his wife had been insufficiently compensated for lost earnings by the CRB. He sought larger payments for inconvenience and distress and time spent pursuing the complaint.

What we found

The lost earnings payment of around £1,500 recommended by the ICM was reasonable, because we felt that it had reasonably based the sum on minding one child part-time – as this was what Mrs M had provided evidence of – rather than more children, as Mr M had said would have been possible had the CRB not taken an excessive time to complete its checks.

The ICM's decision that the redress payment it recommended should encompass inconvenience, distress and time spent was reasonable. However, we found that the CRB's handling of Mr M's check was particularly unacceptable because it involved several periods of significant delay resulting from its unnecessary and incorrect actions, and Mr M had to persistently contact it for progress on his check.

Putting it right

We considered that while the lost earnings payment recommended by the ICM was reasonable, the payment of £500 for worry, distress and time spent did not fully reflect the volume and effect of the CRB's poor handling. Therefore, we recommended that the CRB, in addition to the lost earnings payment, make a payment to Mr M of £1,000. The CRB fully accepted our findings and recommendation.

Organisation we investigated

The Disclosure and Barring Service

Summary 84/April 2014

The hidden cost of immigration delays

A family asked for official permission to stay in the UK. The parents expected a long wait, but they had not expected it to cost them thousands of pounds.

What happened

Mr K and Ms L entered the UK without permission and found work. Their older daughter joined them when she was six. The family asked the Home Office for permission to stay legally in the UK, and had another child. Almost nothing happened on their case for ten years. In that time, the older daughter finished school and went to university. She had grown up in the UK but, without a Home Office decision, she was an overseas student, with higher tuition fees than UK students. The family borrowed money to pay the fees and support her. In 2012 the family got permission to stay permanently in the UK.

What we found

We found serious mistakes in the way the Home Office handled the family's case. It could and should have made a decision earlier than it did. We decided that, without the Home Office's serious mistakes, the family's older daughter would have been able to attend university as a UK student and the family would have avoided around £15,000 in overseas student tuition fees.

Putting it right

The Home Office apologised to the family and paid £15,000 to cover the overseas student tuition fees and £1,000 in apology for the frustration and upset the family endured because of its serious mistakes.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 85/April 2014

Japanese woman turned back at the border

Ms W, who was visiting the UK as a student, found that a short break in Sweden ended with a night in immigration detention.

What happened

Japanese nationals can visit the UK for up to six months without obtaining a visa before they travel. Immigration officials can give them permission to enter on arrival, if the officials believe the person's reasons for visiting the UK make sense under UK immigration law. Ms W and her British boyfriend, who lived in Hong Kong but was visiting England, made a quick trip to Sweden. Ms W did not realise that, having left the UK, she would have to explain again why immigration officials should allow her to enter the UK. At Stansted Airport, immigration officials refused Ms W permission to return. They sent her back to Sweden the next day. Ms W had to spend a night in an immigration detention centre and wear handcuffs when security guards took her through the public area of the airport. A week later, having travelled from Sweden to Paris, Ms W was able to return to the UK. Her friends were outraged at her treatment.

What we found

We partly upheld the complaint. The immigration officials made a mistake in the written reasons they gave to Ms W about why they had refused her entry to the UK – they quoted the wrong part of the law. The private security guards who work with immigration officials did not follow guidance about when to use handcuffs. These serious mistakes damaged Ms W's and her friends' confidence in the quality of the UK border controls. But, overall, officials had been applying UK law to Ms W in line with the standards set for decisions at the border. Even without the serious mistakes, they would have refused her entry to the UK and the security guards would have handcuffed her.

Putting it right

Border Force, which is part of the Home Office, agreed to apologise and to review officials' knowledge of the guidance on when to use handcuffs; and, as part of that, to review Border Force's ability to scrutinise the action of its suppliers.

Organisation we investigated

Border Force

Summary 86/April 2014

Immigration Enforcement handled detainee's complaint about care and treatment poorly

Immigration Enforcement (IE) detained Mr H in an immigration removal centre. He complained about a number of issues, including not receiving appropriate medical care.

What happened

During his detention, IE transferred Mr H to a new location, but did not give him any bedding at the new site. Mr H suffered chest pains and palpitations during his detention, but had to sleep on a top bunk, which he said made him dizzy and his medical problems worse. This was after staff had told him he would be given a bottom bunk. Healthcare staff did not regularly record his blood pressure, even though an independent doctor had asked them to do so. Also, staff did not carry out the electrocardiogram (ECG) ordered by the doctor at the immigration removal centre.

Mr H complained about these matters, but the responses IE gave did not satisfy him, so he asked us to investigate.

What we found

There were excessive delays in the consideration of Mr H's complaint and the complaint handling was poor. IE's responses to Mr H did not address his complaints. We gave IE a chance to give Mr H further explanations and apologies to put this right, but it decided not to do so. There were also problems finding Mr H's medical records, which caused further delays.

IE gave Mr H no information about how bedding was given when a person moved location and no explanation or apology for the delay in giving him a bottom bunk. Also, it did not apologise for failing to monitor his blood pressure and for not carrying out the ECG.

Putting it right

We recommended that IE give Mr H a full acknowledgement of, and apology for, the failings identified in our report, and a sum of £500 as compensation for the delays and the additional distress and worry caused by its poor handling of the complaint.

We also recommended that it works with the healthcare provider at the immigration removal centre to develop and implement an action plan that describes what it has done to make sure that lessons have been learnt from the failings identified by this complaint, to avoid these failings happening again, and to make sure that detainee medical records are kept in accordance with national standards and guidelines. We also recommended that it sets out how it will handle complaints and co-ordinate responses in future, bearing in mind the recommendations made in a report by HM Chief Inspector of Prisons.

Organisation we investigated

Immigration Enforcement (IE)

Summary 87/April 2014

HM Courts and Tribunals Service wrongly said a document was a valid court order

HMCTS told Mr and Mrs D that a document was a valid order because it had a court seal on it. It said this even though the document did not contain key information the rules say it should have on it, including the date it was issued.

What happened

Mr and Mrs D received a document from their opponent's solicitor with a court seal on it. They did not think it was a valid order because it was a draft of an apparent consent order but they had not agreed to it, and it did not have a date of issue or the name of the judge who was supposed to have authorised it.

Mr and Mrs D wrote to HMCTS to ask it whether the document was a valid court order. HMCTS said it was valid because it had a court seal on it and because its computer records showed that the case had been settled by consent early in 2008. HMCTS therefore decided that the document must have been a consent order that Mr and Mrs D had agreed to at the hearing in 2008. Mr and Mrs D told HMCTS that they had not agreed to this or any other consent order. They sent HMCTS a copy of the judge's decision from the hearing in early 2008 – it was different to the document. HMCTS still insisted that it was right to say that the document was a valid document even though there was significant evidence to suggest that it might not have been.

What we found

HMCTS should not have told Mr and Mrs D that the document appeared valid, especially as it did not contain key information. HMCTS cannot decide whether a legal document is valid, only a judge can do that.

Putting it right

We asked HMCTS to apologise to Mr and Mrs D for telling them the document was valid when it should not have done. We also asked HMCTS to apologise for not recognising its mistake sooner and explaining what Mr and Mrs D should do to sort things out.

Organisation we investigated

HM Courts andTribunals Service (HMCTS)

Summary 88/April 2014

HMRC's Tax Credit Office literature found to be misleading

Mrs A used the Tax Credit Office's (TCO) leaflet TC600/10 to fill in her tax credit application form but the leaflet had ambiguous advice that led her to incorrectly tick a box she should not have. This caused Mrs A to be overpaid tax credit, which she had to pay back a year later.

What happened

Mrs A complained to the TCO and the Adjudicator's Office but they did not agree with her that the leaflet was ambiguous or misleading. The TCO recovered all of the overpayment from Mrs A's entitlement, meaning she got less the following year.

What we found

We decided that the leaflet was indeed misleading and if it had not been, Mrs A would not have filled in the form incorrectly. However, we did not find that all of the overpayment had been the TCO's fault.

Putting it right

The TCO paid Mrs A £200 for worry and distress, refunded the part of the overpayment that it caused and apologised to Mrs A for failing to put things right. We did not have to recommend that the TCO amend the leaflet as it had already been amended by the time the complaint reached us.

The Adjudicator's Office apologised to Mrs A for missing the opportunity to put things right.

Organisations we investigated

Adjudicator's Office

HM Revenue & Customs (HMRC)

Tax Credit Office (TCO)

Summary 89/April 2014

Cafcass's poor communication caused aborted hearing

Cafcass's mishandling of Mr G's case caused stress, inconvenience and wasted time.

What happened

The court ordered Cafcass to file a report and make a referral for contact between Mr G and his children. Cafcass said it could not make the referral until it had completed a risk assessment. However, Cafcass did not tell the court that it couldn't comply with the order. It also filed the report late. At the next hearing, the judge could not progress matters as the report had not arrived at the court and the contact had not taken place. The hearing was aborted and rescheduled.

What we found

Cafcass should have acted sooner to tell the court that its guidance and the court order were incompatible. Cafcass failed to communicate effectively with the court, which caused frustration and confusion during the next hearing. Further, the Cafcass officer failed to file a report on time, which led to a hearing being aborted. Cafcass also mishandled Mr G's complaint.

Putting it right

Cafcass apologised to Mr G for its handling of his case and complaint, paid him £250 in recognition of stress, frustration and wasted time, and implemented a systemic remedy to make sure that its staff were clear about the required time frames for filing documents to the court by various methods.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 90/April 2014

Development Agency wrongly awarded over £150,000 grant to rural centre

Equestrian Centre B asked for compensation for 'displacement' of its business because of what it alleged was a development authority's wrongful approval of Equestrian Centre F's funding application.

What happened

In 2009 Equestrian Centre F applied to its Regional Development Authority for Rural Development Programme for England (RDPE) funding to build a second indoor arena. The Department for Environment, Food and Rural Affairs (Defra) had overall responsibility for RDPE funding. When it looked at the funding application, the Authority relied on an informal process and the integrity of the application. Guidance to applicants asked them to identify their competitors and say why their publicly-funded proposal would not affect or 'displace' their competitor's business. Equestrian Centre F did not do this because it said its business was unique, so it did not have competitors. This, together with other assertions it made, was false. But the Authority approved the application because it did not check any of the assertions.

After Equestrian Centre B complained, an independent expert instructed by the Authority said many assertions in Equestrian Centre F's application were false. Defra referred the matter to its internal police who, after an investigation, sent a file to the Crown Prosecution Service (CPS). The CPS ultimately did not prosecute as it was not in the public interest because Defra had the right to claw back the money.

Meanwhile, Defra's response in summer 2011 to Equestrian Centre B's complaint found that the Authority had not handled the complaint well. Defra asked one of its senior officials, in autumn 2011, to examine how the Authority considered displacement in Equestrian Centre F's application. The senior Defra official found several weaknesses in the Authority's consideration of displacement but found that overall it followed the available guidance and did not poorly assess displacement.

What we found

The Authority's appraisal process was not written and so was unclear and could lead to inconsistent decisions. Its process had not followed general HM Treasury guidance and we found that its appraisal consisted only of reading a sample of testimonials. The process was flawed and that was maladministration. The Authority did not check anything in the application and so missed the false assertions. It therefore approved an application it should not have. That was also maladministration.

Defra's handling of Equestrian Centre B's complaint was poor. This was because, although the complaint resulted in three separate reports and a criminal investigation, Defra did not link the conclusions of these reports and relate them to the Authority's consideration of displacement. That meant it did not answer Equestrian Centre B's complaint. This was further maladministration.

The Authority's maladministration would have had some small impact on Equestrian Centre B. However, Equestrian Centre B had not given us clear evidence of financial impact such that we could make a recommendation for a specific financial loss. But it left Equestrian Centre B with uncertainty about the impact on its business. Defra's denial for over three years that it poorly assessed displacement when appraising Equestrian Centre F's application was also frustrating and stressful for Equestrian Centre B.

Putting it right

Defra apologised to Equestrian Centre B for its maladministration and the impact it had had. It paid the complainants £2,000 compensation. Defra said it had made significant changes to the schemes it offered, including a range of controls over the assessment of applications. This included lessons learnt from this case. Defra undertook to emphasise to appraisal staff that they must check facts and assertions. Defra agreed to include this in guidance to be published in January 2015.

Organisation we investigated

Department for Environment, Food and Rural Affairs (Defra)

Summary 91/May 2014

Cafcass was correct to tell Ms N that she should challenge its officer's judgment in court

Although Cafcass was right to tell Ms N that she should challenge its report in court, a Cafcass officer was wrong when she failed to go to all the court hearings.

What happened

Ms N complained about the way that Cafcass dealt with her family. She was unhappy about: the actions of the Cafcass officers assigned to her family; the impact that contact sessions had on her children; and the actions of the provider of the contact sessions. Ms N said that Cafcass had caused her family emotional and mental distress.

What we found

Cafcass's recommendations were based on the professional judgment of the officers involved in the case. When Ms N complained about that, Cafcass said that she should have raised those complaints in court, as that was the right place to do that. Cafcass was right to say that to Ms N.

Cafcass officers had not attended some of the court hearings, when the court had ordered that they should. We found that this was maladministration on Cafcass's part. However, we found that this had not caused Ms N any injustice because the court decided that it could proceed with the hearing without the officers, and she could have challenged that view in court, had she disagreed.

Cafcass dealt with Ms N's complaint appropriately, and the information it gave us about the provider of the contact sessions was reasonable.

Putting it right

We partly upheld this case because we found maladministration, but we also found no injustice that had affected Ms N as a result of that maladministration. We therefore made no recommendations.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 92/May 2014

Child Support Agency takes more than seven years to do the right thing

The Agency's poor case handling meant Ms C struggled for seven years to get it to act properly. Its failings had a huge impact on her mental health and caused her to attempt suicide.

What happened

Ms C's former partner was working and also claiming benefits. The Agency was aware of this from as early as spring 2005 but it failed to take the correct action. When Ms C's former partner stopped paying maintenance in winter 2005, the Agency decided that he did not owe any child maintenance and later refunded the money that he had correctly paid.

Ms C told the Agency about its mistakes from 2006 onwards but it did not change her former partner's maintenance assessment or correct its mistakes, even after it realised that it had got things wrong.

Ms C regularly asked the Agency to make her an advance payment of the unpaid maintenance because of its mistakes but it refused to do so. When it refused again in summer 2011, Ms C made an attempt on her own life. The Agency was told about this but did not change the way that it handled the case as a result.

Independent Case Examiner (ICE) investigated the complaint and recommended that the Agency make Ms C an advance payment for all the unpaid maintenance plus interest. It also recommended that it make her a consolatory payment of £500.

What we found

We agreed with ICE's investigation and findings but we concluded that its recommendations did not go far enough to recognise the impact on Ms C of the Agency's poor handling of the case and its failure to make the right adjustments for her once it became aware of her attempted suicide.

Putting it right

The Agency paid Ms C a further consolatory payment of £3,000 and arranged for a senior manager to apologise to her.

Organisations we investigated

Child Support Agency (CSA)

Independent Case Examiner (ICE)

Summary 93/May 2014

The Student Loans Company paid the correct grant for childcare but did not properly consider personal reasons for a study grant

Miss W gave compelling personal reasons for not completing a year of her course but the Student Loans Company (SLC) did not tell her whether or not it would accept them. This influenced whether she would receive a Special Support Grant in the next academic year.

What happened

Miss W complained to the SLC about problems she had with the Childcare Grant in 2012-13 and that it had not considered the serious personal reasons why she had not completed the previous academic year. The SLC explained what payments she had received for her Childcare Grant. It initially said that it did not consider Miss W's compelling personal reasons because they related to an incident in 2009-10. When this was proved to be wrong, it said that it would not consider them because they related to events after the end of the 2011-12 academic year.

What we found

The SLC had paid Miss W the correct Childcare Grant in 2012-13. It should have considered Miss W's personal reasons because they still related to events in the 2011-12 year, even if they happened after the end of the final term.

Putting it right

The SLC apologised to Miss W, and looked again at her personal reasons.

Organisation we investigated

Student Loans Company (SLC)

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 94/May 2014

UK Visas and Immigration (UKVI) delayed deciding an Iraqi asylum seeker's request to stay in the UK

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

What happened

In 2001 Mr S came to the UK from the Kurdish area of 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 late 2008 Mr S's representatives wrote to UKVI and asked it to reconsider Mr S's asylum claim on some new evidence. In autumn 2009 Mr S's MP asked UKVI when it would decide Mr S's request. However, UKVI found no trace of having received it.

Mr S's MP sent UKVI a copy of the missing letter. UKVI received the copy in late 2009, but instead of deciding it, added it to the backlog of 'legacy' cases it was dealing with. UKVI told Mr S's MP it would decide his case by summer 2011, but it did not do so. Meanwhile, Mr S married and in spring 2013 he asked UKVI to reconsider his case again because his wife was expecting their first child. In winter 2013 UKVI finally decided Mr S's request to stay. It refused his requests for asylum, but granted him permission to stay in the UK for 30 months because of his new circumstances.

What we found

UKVI had mixed up Mr S's records with the records of another Iraqi asylum seeker. In autumn 2009 UKVI told Mr S's MP that it needed to correct this error and would contact the MP again when it had done so. UKVI corrected the error quickly, but then forgot to tell Mr S or the MP it had done so. It then put his case in its queue of cases to be decided, where it remained. In autumn 2010 UKVI told Mr S's MP it was on track to decide his case by summer 2011. UKVI should have decided Mr S's case by this time, and its failure to do so was maladministrative, as was its failure to answer any of Mr S's representatives' enquiries about when his case would be dealt with.

Putting it right

If UKVI had dealt with Mr S's first request to have his asylum claim reconsidered in mid-2011, when it should have done, UKVI would have refused him permission to stay in the UK. Therefore, Mr S benefited from its delayed handling of his case. However, he was inconvenienced by the need to pursue his case through representatives. UKVI apologised to Mr S for not dealing with his first request for his asylum claim to be reconsidered sooner, and also for not replying to his representatives' enquiries.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 95/May 2014

Border Force repeatedly charged the wrong rate of import VAT

Mr D collects coins and regularly imports goods to the UK by post. Often the parcels are charged the wrong rate of import VAT, even though the customs declaration on each parcel is correct. Mr D frequently has to claim refunds of the wrongly-charged VAT.

What happened

Mr D complained to Border Force several times about its repeated failure to charge the right amount of VAT on parcels imported to the UK. Despite Border Force's assurances that it had taken action to make sure that staff check the customs information on the parcels, staff continued to charge the wrong rate of VAT.

What we found

Border Force staff often did not take account of the customs information on parcels imported to the UK by post so the wrong rate of VAT was charged, and Mr D had to claim a refund of the amount overcharged. Border Force took too long to process the refund applications and failed to meet its service standards. Despite Border Force's assurances that it had taken steps to put things right, the charging errors and delays continued. Border Force did not put things right.

Frequently charging the wrong amount of VAT caused Mr D a great deal of time and trouble, inconvenience and frustration. The delays dealing with the refunds of VAT left Mr D out of pocket. Border Force's failure to put things right added to Mr D's frustration and inconvenience.

Putting it right

Border Force apologised to Mr D and agreed to review procedures, take steps to prevent the mistakes happening in future, and reduce the time taken to process refunds.

Organisation we investigated

Border Force

Summary 96/May 2014

Border Force repeatedly charged the wrong rate of import VAT – again

Mrs B collects Japanese antiques and regularly imports goods into the UK by post. Often the parcels are charged the wrong rate of import VAT, even though the customs declaration on each parcel is correct. Mrs B frequently has to claim refunds of the wrongly-charged VAT.

What happened

Mrs B complained to Border Force several times about its repeated failure to charge the right amount of VAT on parcels imported into the UK. Despite Border Force's assurances that it had taken action to make sure that staff checked the customs information on the parcels, staff continued to charge the wrong rate of VAT.

What we found

Border Force staff often did not take account of the customs information on parcels imported to the UK by post so the wrong rate of VAT was charged, and Mrs B had to claim a refund of the amount overcharged. Border Force took too long to process the refund applications and failed to meet its service standards. Border Force did not 'get it right'. Despite Border Force's assurances that it had taken steps to put things right, the charging errors and delays continued.

Mrs B had to spend time and money dealing with Border Force's failure to charge the right amount of VAT. Border Force's delays left her out of pocket, and its failure to put things right added to Mrs B's frustration and inconvenience.

Putting it right

Border Force has agreed to write to Mrs B to apologise and pay her £160 compensation. Border Force has also agreed to review its procedures and take steps to prevent the mistakes happening in future and reduce the time taken to process refunds.

Organisation we investigated

Border Force

Summary 97/May 2014

Independent Case Examiner's investigation failed to fully consider injustice

A man who considered the Independent Case Examiner (ICE) had carried out an inadequate investigation of Jobcentre Plus complained to us.

What happened

ICE investigated Mr P's complaint that his workplace provider had failed to consider his caring responsibilities when making referrals to Jobcentre Plus to consider sanctioning his benefit. ICE also investigated whether Jobcentre Plus failed to take appropriate action to tell Mr P about sanctions to his benefit, and failed to address his complaints. ICE partly upheld Mr P's complaint. ICE found that Jobcentre Plus failed to tell his workplace provider about the restrictions placed on his jobseeker's agreement that showed the specific hours that he was available for work. However, ICE said it expected Mr P to point this out to the workplace provider when it told him to attend mandatory appointments outside those hours. ICE found that the workplace provider acted correctly in sending referrals to Jobcentre Plus when Mr P failed to attend those appointments. ICE said the correct route to challenge sanctions is to ask for a review of the decision or to submit an appeal. ICE considered it was not maladministrative for different decision makers to make different decisions in initially sanctioning Mr P's benefit, but revised that decision when he appealed. ICE found that Jobcentre Plus had correctly disallowed Mr P's benefit when he refused to sign a new jobseeker's agreement.

ICE considered Jobcentre Plus had handled Mr P's complaint poorly. It recommended that Jobcentre Plus apologise for its failings. It did not make any recommendations for redress as it considered the review and appeal process was the correct route for it to challenge Jobcentre Plus's decisions. Mr P was unhappy with ICE's investigation and approached us.

What we found

Although Jobcentre Plus told the workplace provider that there were restrictions on Mr P's jobseeker's allowance agreement, it did not explain that it should only make mandatory appointments for the times that Mr P was available for work. Mr P was not aware that appointments should have been made in accordance with his jobseeker's agreement.

ICE did not fully consider the effects of Jobcentre Plus's poor communication, which resulted in unnecessary referrals and the imposition of sanctions. It was clear that the initial sanction decisions were fundamentally wrong. ICE's investigation was flawed because it reached inappropriate conclusions. This meant that Mr P was put to the trouble of complaining to us, and was left feeling that ICE had dismissed his complaint.

Jobcentre Plus's failure to make it clear that appointments should be made for the times that Mr P was available for work was maladministrative. Furthermore, it had plenty of opportunities to set the record straight, but failed to do so, which lead to more unnecessary referrals and sanctions. As a result of its actions, Mr P suffered stress, inconvenience and aggravation because his benefit was stopped. He also had a real sense of worry that Jobcentre Plus would needlessly stop his benefits again.

Putting it right

ICE apologised and paid Mr P £150 in recognition of the effect of its failings.

Jobcentre Plus apologised and paid Mr P £500 in recognition of the effect of its failings. It also made a commitment to pay any bank charges Mr P incurred because of its failings. Jobcentre Plus showed us how it will make sure that workplace providers are told about restrictions on an individual's jobseeker's agreement and how those restrictions affect the arrangement of appointments, and so on.

Organisations we investigated

Independent Case Examiner (ICE)

Jobcentre Plus

Summary 98/May 2014

Man moved home after data breach by Jobcentre Plus

When Mr M's personal data was breached by a Jobcentre Plus employee, it tried to put things right but we thought there was more that it could do.

What happened

Mr M was approached by someone who had previously abused him. This person knew who he was because a Jobcentre Plus employee had shared Mr M's confidential information. Mr M moved to a different part of the country to avoid the abuser.

After a thorough investigation, Jobcentre Plus accepted responsibility for the breach and made Mr M a payment for the impact of the situation on his wellbeing and to recognise that it had caused a major disruption to his life. Mr M asked it to increase the payment. He told Jobcentre Plus that he had moved to a different part of the country to avoid the person. He said this had caused him stress, inconvenience and financial loss. Jobcentre Plus did not increase the payment until the complaint was investigated by the Independent Case Examiner (ICE), which recommended a further payment for financial loss.

Mr M explained that he had felt he had no choice but to move, and this had caused him a lot of emotional upset. He said the move meant he no longer had any support to help him get over what had happened.

What we found

Jobcentre Plus did a good job of investigating the data breach and its payment was fair in light of the impact on Mr M. We also agreed with ICE's conclusions and the additional payment that it had recommended. While we could not recommend any action that would undo what had happened, we decided that there was more that Jobcentre Plus could do to put right the loss of Mr M's support network.

Putting it right

We recommended that Jobcentre Plus make Mr M an additional consolatory payment of £2,000.

Organisations we investigated

Independent Case Examiner (ICE)

Jobcentre Plus

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 99/May 2014

HMRC's explanation of Mr B's tax affairs was unclear

HM Revenue & Customs (HMRC) repeatedly failed to clarify Mr B's current tax affairs. This led to confusion, worry and uncertainty.

What happened

Mr B disputed the repayment figures HMRC provided as these did not add up. Mr B had been asking for clarification for a long time. However, HMRC did not provide the full picture and the figures, and the way they were presented, were very confusing.

What we found

HMRC's explanations and figures were unclear, confusing, incomplete and, in our view, not fit for purpose. The figures HMRC gave Mr B did not add up and a further, accurate and easy to understand explanation was necessary.

Putting it right

HMRC sent Mr B a table that showed the history of his tax affairs. It also paid Mr B a consolatory payment of £125 for worry and distress and poor complaint handling. We were satisfied that the table was easy to understand and accurate. Mr B was happy with our recommendations.

Organisation we investigated

HM Revenue & Customs (HMRC)

Summary 100/May 2014

No compensation for field owner after Rural Payments Agency (RPA) errors

RPA's failure to automatically send a field owner a 2010 Single Payment Scheme (SPS) claim form and guidance was not the sole or direct cause of the field owner's failure to claim SPS in 2010.

What happened

Mr P bought a field and wanted to claim SPS the next year. A newcomer to the scheme, he had learnt something about SPS from the farmer who sold him the field. During telephone calls with RPA he registered with RPA and made sure that RPA had registered the field. Mr P said that during an early winter 2009 call, RPA told him he need do nothing more regarding his SPS claim because it would automatically send him the claim form and guidance for 2010. Errors by RPA's IT partner in spring 2010 meant that this did not happen. Mr P was so busy moving house that he did not think to chase RPA for the 2010 claim form and guidance. Mr P did not contact RPA until late winter 2010 when it told him he would not receive any payment for 2010 because he had not submitted a claim. RPA did not tell Mr P what matters its complaints procedure could examine and so Mr P appealed RPA's decision not to pay him SPS for 2010 as the only way to contest that decision. Mr P lost the appeal. Mr P's case was that RPA's failure to automatically send him the claim form was the sole reason he did not submit a claim and so did not receive payment.

What we found

We partly upheld Mr P's complaint. RPA's IT partner's error was the responsibility of RPA. It failed to do something it had promised its customers it would do. RPA's failure to explain to Mr P what its complaints procedure could and could not do meant that Mr P wasted £100 in appeal fees and associated travel costs in attending an appeal hearing at which he had no chance of success. It also took RPA two years to tell Mr P why it had not automatically sent him a claim form and guidance. That was too long. Together, these shortcomings amounted to maladministration.

However, Mr P knew that he had to complete and submit a claim form to obtain SPS payment. It would have been reasonable for Mr P to telephone RPA to find out when it would send the form. RPA's failure to send the claim form did not directly result in Mr P's failure to claim SPS in 2010.

Putting it right

RPA apologised to Mr P for its maladministration but Mr P declined that offer. RPA paid £250 compensation to Mr P for its poor complaint handling, refunded his £100 appeal fee and reimbursed his reasonable travel costs.

Organisation we investigated

Rural Payments Agency (RPA)

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 101/May 2014

Information Commissioner clarified matters for a complainant

Mr V complained that the Information Commissioner's Office (ICO) had not answered his question properly, but we found that once we were involved, ICO resolved the complaint.

What happened

Mr V complained that ICO had not answered his questions about how *The Road Vehicles (Registration and Licensing) Regulations 2002* (the Regulations) interacted with the *Data Protection Act 1998* (the Act). He wanted to know whether the Regulations could effectively override the Act, and if they could, he wanted an explanation of why that was.

What we found

ICO sent several emails to Mr V to answer his question. It was only once we became involved that it provided him with a reasonable response, which gave him the answer he needed. ICO apologised for that fact. However, some of that response confused Mr V further because it criticised some of its earlier work, which was not justified. ICO clarified that for us, and confirmed that its handling of Mr V's complaint had not been as bad as it had originally suggested. We partly upheld the case as a result.

Putting it right

ICO apologised to Mr V for its mistakes as soon as we were involved. It later gave us more information which clarified its position. We were able to pass that to Mr V, to resolve the confusion.

Organisation we investigated

Information Commissioner's Office (ICO)

Summary 102/May 2014

Teacher waited 17 years for injuries benefit

Mr A claimed industrial injuries disablement benefit over 20 years ago following an accident on his way home from a work course. Jobcentre Plus dismissed his claim. He tried to appeal several times but failed. After the tribunal decided in 2010 that he should receive the benefit, Jobcentre Plus paid Mr A the money for the 17 years he had missed out on but failed to pay him interest on that sum.

What happened

Mr A first applied for the benefit in 1993. Jobcentre Plus decided not to award it to him. He appealed to a tribunal the following year but it too dismissed his claim. From 2004 (when Mr A's father read about a legal case that meant that his son should have received the benefit), Mr A tried again to claim the benefit. However, Jobcentre Plus and the tribunals refused several times. They said the decision could not be changed because a tribunal decision had been made in 1994. Jobcentre Plus had incorrectly destroyed Mr A's papers so neither it nor a tribunal could say whether that original decision was right.

In 2010 Mr A's father found copies of some of the missing papers and appealed to the upper tribunal. The tribunal reversed the decision of the 1994 tribunal and so Jobcentre Plus finally paid Mr A his money 17 years after his original claim. However, it did not pay him interest on his benefit payment. Mr A's father complained to Jobcentre Plus and then the Independent Case Examiner (ICE) but both refused to award him interest. Mr A's father then complained to us.

What we found

Jobcentre Plus's original decision in 1993 on Mr A's claim was wrong because it was not in line with the relevant case law. And because Jobcentre Plus did not tell the tribunal about the case law, the tribunal did not have all the information it needed to make an informed decision.

Jobcentre Plus then missed several opportunities to correct its mistake and when it finally paid Mr A his benefit in 2010, it did not pay him interest on it.

ICE failed to consider all the circumstances of Mr A's case and to put right Jobcentre Plus's mistakes. It missed the exception in Jobcentre Plus's policy that said that interest could still be awarded if the original decision was wholly unreasonable or clearly incorrect, as it was in this case.

Putting it right

Jobcentre Plus and ICE apologised to Mr A. Jobcentre Plus paid him interest on the money that he missed out on from 1993 to 2010, along with interest from late 2010 to the present on the interest payment he should have received in 2010.

Jobcentre Plus and ICE each paid Mr A £500 for the significant frustration, distress and inconvenience this caused.

Organisations we investigated

Independent Case Examiner (ICE)

Jobcentre Plus

Summary 103/May 2014

Outcome of Civil Aviation Authority investigation not explained well

When the Civil Aviation Authority (CAA) investigated a complaint by Mr C, it did not clearly explain its decision to take no action.

What happened

Mr C lived near a flying club and aeroplanes regularly flew over his home. On one very windy day, Mr C was concerned to note that aircraft continued to fly in what Mr C considered to be dangerous conditions. He complained to the CAA, who carried out an investigation, but decided against taking any further action.

What we found

We found that although the CAA had carried out an investigation, it did not clearly explain the outcome of that investigation to Mr C. Its responses to him did not explain why it thought the flights were safe on that day.

Putting it right

The CAA apologised to Mr C for this failing and met Mr C to explain the outcome of its investigation.

Organisation we investigated

Civil Aviation Authority (CAA)

Summary 104/June 2014

OFT's decision was based on an overly narrow view

The Office of Fair Trading (OFT) did not tell Mr J about its investigations into a company and its reprimand of that company.

What happened

The OFT refused Mr J's request for the release of information via the gateway provided by section 241A of the *Enterprise Act 2002*. The gateway allowed the release of restricted information for the purpose of civil proceedings.

What we found

The OFT's refusal was partly based on an overly narrow view of the provisions in section 241A. The OFT thought that civil proceedings should be likely or imminent, but that view failed to give the full legislative intent to the provision. This included the release of information to enable legal advice to be obtained on whether a claim was possible and worthwhile. The Competition and Markets Authority (who responded to our investigation as the OFT has since been abolished) accepted that:

'the OFT's position cannot be said with confidence to represent the better view on the interpretation that should be given to the s241A gateway.'

Putting it right

Given the errors we found in the OFT's decision making, we could not be satisfied that it had made the correct decision. The Competition and Markets Authority offered to consider a fresh request for information from Mr J.

Organisation we investigated

The Office of Fair Trading (OFT)

Summary 105/June 2014

Cafcass closes case in error

Cafcass's administrative errors caused a father extra distress at an already difficult time.

What happened

Mr A's partner left the family home and took their daughters with her so Mr A made an application for contact and residency. The family court adviser assigned to the case went on maternity leave before the final hearing that she was supposed to attend. Cafcass had no record that the hearing was outstanding so closed the case in error. When this came to light at the hearing, the case was assigned to a second family court adviser and another final hearing was listed. The second family court adviser delayed telling the court that the hearing fell on her non-working day so it had to be rearranged again.

Mr A complained to us and said that Cafcass's errors delayed the case. He said that this delay damaged his relationship with his daughters and gave their mother a chance to turn them against him. He said that all this meant he had no chance of having a fair final hearing. He was seeking compensation for the pain that this caused him.

What we found

Cafcass made errors in its handling of the case and these errors probably caused some delay. However it was difficult to say how much delay was caused because we found reasons that suggested matters may not have been resolved quickly, even if Cafcass had not made the mistakes it made. We did not find that the delays ruined Mr A's chances in the court proceedings.

Putting it right

Cafcass paid Mr A £200 in recognition of unnecessary frustration it had caused.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 106/June 2014

Three serious mistakes by Cafcass

Cafcass wrongly told a man with dyslexia that he could not have anyone with him at interview, did not check information before putting it in a report and did not recognise or apologise for its mistakes.

What happened

Cafcass did not interview Mr S before writing a report to the court. It also put information in its report without any evidence to show that it had asked Mr S or his daughter about it. Cafcass failed to recognise its mistakes, which forced Mr S to complain to us.

What we found

Cafcass made three mistakes: it failed to realise that Mr S's father could have been at his interview; it put information in its report about Mr S's parents sharing his daughter's care without consulting him or his daughter and without making sure that this information was correct; and it failed to recognise or apologise for its mistakes throughout the complaints process.

Cafcass's mistakes made Mr S feel unfairly treated and that he had not been given a reasonable opportunity to put his point across. The mistakes also caused Mr S frustration by failing to resolve matters through the complaints process.

Putting it right

Cafcass apologised to Mr S and paid him £750. It also wrote to the court so that our findings are on record; took steps to make sure its staff know that people are allowed to have someone with them at interview; and took steps to make sure it handles complaints in line with its own processes and that complainants with a genuine grievance are not labelled as '*vexatious*'.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 107/June 2014

Cafcass failed to amend incorrect safeguarding information

Cafcass missed several opportunities to correct a serious error in its safeguarding report.

What happened

Cafcass wrote a safeguarding report, but wrongly said that information from the police related to Mr G, when it actually related to a third party. This information incorrectly suggested that Mr G suffered from a particular mental health condition, which he did not. Mr G repeatedly told Cafcass about its mistake, but it failed to correct this. Cafcass also overlooked correspondence from the police, who also tried to alert Cafcass to the issue. Mr G spent a long time resolving matters with the police and when he was finally able to complain to Cafcass, it refused to consider his complaint because of the time that had passed.

What we found

Cafcass misinterpreted information from the police, causing it to include incorrect information in its safeguarding report. It then missed several opportunities to put things right. Cafcass's decision not to look at Mr G's complaint was unreasonable when he had provided clear evidence of its mistake. This situation would have been very frustrating for Mr G.

Putting it right

Cafcass apologised to Mr G and paid him £250. It also amended its records and notified the court of its error.

Organisation we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 108/June 2014

Child Support Agency put things right, but Independent Case Examiner (ICE) missed an opportunity

Mr F complained that the Agency backdated arrears and did not properly consider evidence of his payments.

What happened

In early 2012 the mother of Mr F's son asked the Agency to review the amount that Mr F was paying in child maintenance. (It had previously done a calculation and he paid her directly.) In spring 2012 the Agency told Mr F that the amounts had increased and that this was effective from the end of 2011. Mr F did not pay the arrears that had accumulated from late 2011 and so his son's mother asked the Agency to collect the payments from him. It sought evidence about how much Mr F had paid during that period and then tried to recover the arrears.

Mr F complained to ICE, which told him that it was satisfied with the Agency's view that he had not provided sufficient evidence of all of the payments that he said he had made.

What we found

ICE's view in terms of the payments was a reasonable one. ICE had not properly considered concerns that Mr F had raised about budget difficulties when the Agency took so long to make a decision and then backdated it. We looked at that and found that the Agency had taken six weeks longer than its published service standard to complete the reassessment. We noted that it had apologised for that before Mr F complained to ICE, which we considered to be a reasonable remedy. We did not, therefore, consider that any of the injustice that Mr F claimed linked to ICE's error.

Putting it right

We made no recommendations because the Agency had already corrected its mistake, while ICE's error did not link to the injustice that Mr F had claimed.

Organisations we investigated

Child Support Agency (CSA)

Independent Case Examiner (ICE)

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014. This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 109/June 2014

A farmer's paper chase

Mr H and the Rural Payments Agency (RPA) needed to agree the exact details of the land he farmed. It resulted in a paper chase that lasted three years.

What happened

In autumn 2009, RPA asked Mr H to agree a set of maps for his farm. It asked for a reply within a month but it took Mr H until spring 2010 to reply. RPA took until spring 2012 to deal with his letter and then only after Mr H had started chasing it for action in winter 2011. After three letters from him, including a complaint letter to the Secretary of State, the mapping experts got in touch. Then, separately, the mixed-up map data led another part of RPA to say Mr H had over-claimed farming subsidy. In early 2013 RPA decided that he had given it enough information for his claim to be correct. It apologised, but declined to pay Mr H for the cost of his time and office expenses in pursuing his complaint. He estimated his costs came to £1,750. Mr H was also seriously ill for part of the time that he was in touch with RPA.

What we found

We partly upheld Mr H's complaint. RPA should have dealt with his letter of spring 2010 as soon as possible after receiving it, even if he had been late with his reply. When the mapping experts dealt with Mr H's up-to-date mapping information in 2012, they were not clear that another part of the organisation was dealing with his claim for subsidy and would also need to know his up-to-date information. We could not make a robust argument that the effect of dealing with RPA amounted to a financial cost of £1,750. But its mistakes contributed to Mr H's difficulties. RPA did not know about Mr H's illness, but pursuing his complaint when he was unwell must have been difficult.

Putting it right

RPA apologised to Mr H for the effect of its serious mistakes and paid him £200.

Organisation we investigated

Rural Payments Agency (RPA)

Summary 110/June 2014

New Zealand citizen waited over four years for routine decision on application to settle in the UK

UK Visas and Immigration (UKVI) made a series of mistakes dealing with an application to settle in the UK from Mr D, who had already lived here for 14 years, forcing him to wait an extra four years for a decision.

What happened

Mr D was entitled to apply to settle in the UK as he had already lived here for 14 years. His application was sent to the correct settlement team at UKVI but was then transferred to a unit dealing with a backlog of old asylum applications, even though Mr D was not an asylum-seeker. UKVI did not look at his application for three years. It then wrote to him at an incorrect address and when it did not receive a reply, put his case into storage. A year later, UKVI sent his application back to the correct team for a decision.

What we found

Mr D's case was straightforward. His application should have remained with the original settlement team and he could have expected a decision over four years earlier than he did. Even when his case went to the wrong team, UKVI continued to make mistakes: it wrote to him at an incorrect address and incorrectly put his application into storage. As a result, Mr D suffered an unnecessary delay of over four years, causing him stress and anxiety. He was also denied an opportunity to apply for work and was unable to contribute towards household costs.

Putting it right

UKVI apologised to Mr D and paid him £2,500 in recognition of over four years of missed opportunities to apply for work, stress and uncertainty.

Organisation we investigated

UK Visas and Immigration (UKVI)

Summary 111/June 2014

Jobcentre Plus carried out a reasonable investigation, but the Independent Case Examiner (ICE) did not

Jobcentre Plus deducted the wrong amount from Miss P's benefit for about two and a half years and paid this to the water company she owed money to.

What happened

The water company told Jobcentre Plus that Miss P owed it money. Jobcentre Plus began taking amounts from her benefit and giving them to the water company. Two and a half years later the water company told Jobcentre Plus that incorrect amounts had been deducted and paid to it. The water company has now refunded this money to Miss P.

Miss P complained to Jobcentre Plus and ICE and was not satisfied with the outcome.

What we found

Neither Jobcentre Plus nor the water company had kept the records of the transfer, so we could not say what had happened. There was not enough evidence to find against Jobcentre Plus and we did not uphold the complaint about it.

ICE did not get information from the water company to enable it to draw robust conclusions about Miss P's complaint, which was maladministrative. We did not find that the maladministration linked to any of the injustice claimed.

Putting it right

We made no recommendations because ICE's maladministration did not link to any of the injustice claimed.

Organisations we investigated

Independent Case Examiner (ICE)

Jobcentre Plus

Summary 112/June 2014

Lost pension entitlement: what can we do when no evidence is available?

Ms W missed out on a lump sum when she decided not to collect her state pension for the first two years after she became eligible for it. Her other benefits meant that she could not defer her claim for more than 12 months.

What happened

Ms W became eligible to collect her state pension in 2011 but decided not to retire for a further two years. She expected to receive a lump sum of backdated pension when she began claiming her state pension in 2013. However, because she had been receiving widow's benefit, she could not backdate her pension for more than 12 months.

Ms W says that she spoke to the Pension Service when she decided to defer her pension and told it about her plans and her widow's benefit. She says the adviser that she spoke to told her that she did not need to do anything until she wanted to claim her state pension. In fact Ms W could have stopped claiming her widow's benefit at that time. Had she done so, she would have received the lump sum for the whole two years.

When Ms W complained to the Independent Case Examiner (ICE) it explained that there was no evidence of the telephone calls that she had made to the Pension Service. It added that information about her situation was included in leaflets and in a pension forecast that was sent to her before she decided to defer claiming her pension. Because of this, ICE said it could not say that the Pension Service had given her the wrong advice.

What we found

There was no evidence available to show that Ms W had spoken to the Pension Service or what advice it had given her. This meant that there was no information available to support her view that she had been given the wrong advice. When we considered this and the fact that the information that she had received showed that her widow's benefit might have an impact on any lump sum, we found that ICE had got it right in this case. We did not uphold Ms W's complaint.

Organisation we investigated

Independent Case Examiner (ICE)

Summary 113/June 2014

HMCTS's failure to get court papers to judge led to hearing postponement and unnecessary costs

A hearing on contact and residence for Ms A's children had to be postponed for four months because HMCTS did not send the court papers to the judge. HMCTS refused to pay Ms A's legal costs for the postponed hearing.

What happened

The final hearing to decide contact and residence for Ms A's children was transferred to another court, but HMCTS did not send the court papers to the judge and the hearing was rescheduled. Ms A asked HMCTS to reimburse her for her costs in hiring a barrister and solicitor for the postponed hearing. HMCTS agreed it had made a mistake in not sending the court papers to the judge, but did not accept that that was the reason for the hearing being postponed. It offered Ms A £100. She was unhappy with HMCTS's response.

What we found

The hearing was postponed because HMCTS had not sent the papers to the judge. HMCTS could not track the court papers so no one knew where they were. Ms A had appointed a barrister to represent her for what she believed was going to be the final hearing, but, through no fault of her own, had to engage the barrister again for the final hearing, so her costs for the postponed hearing were wasted. HMCTS did not provide a good service in responding to Ms A's complaint.

Putting it right

HMCTS apologised to Ms A and reimbursed her wasted legal costs of around £2,800. It also paid her £300 compensation for the stress and inconvenience it had caused her. HMCTS reviewed the lessons learnt from this complaint with a view to improving the tracking of case bundles so that there is a clear audit trail.

Organisation we investigated

HM Courts and Tribunals Service (HMCTS)

Summary 114/June 2014

HMCTS failed to put evidence before judge

HMCTS failed to put Mrs S's evidence bundle before the judge. Mrs S believed she suffered financial loss as a result.

What happened

Mrs S went to a small claims court for a hearing about a rental property. HMCTS failed to put Mrs S's evidence bundle before the judge at the final hearing. Mrs S made the judge aware that he had not seen her evidence during the hearing and the judge said that he would look at the copy she had in court if he needed to. The judge awarded in Mrs S's favour but he did not recommend the level of payment she thought she was owed.

What we found

The judge knew he had not seen Mrs S's evidence bundle. He also knew that Mrs S had a copy of the evidence bundle in court and he said that he would look at it if he needed to. HMCTS's mistake did not limit the judge's ability to consider Mrs S's evidence, if that was what he felt he needed to do.

The judge made certain decisions about the case that meant he did not need to see Mrs S's evidence of her costs before spring 2007. It was these costs that Mrs S believes she lost out on because of HMCTS's failure to give the judge her evidence. We did not agree with Mrs S that the judge would have reached a different conclusion if HMCTS had given him her evidence in time for the hearing. We cannot say what a judge would or would not have done if the circumstances had been different and we cannot make a judicial decision. In our view, however, the evidence did not suggest that HMCTS's mistake caused Mrs S financial loss.

HMCTS had apologised to Mrs S for its failing before she came to us. We considered that it had, by apologising, already put matters right and that there was nothing further we could do for Mrs S. We did not uphold her complaint.

Organisation we investigated

HM Courts and Tribunals Service (HMCTS)

Summary 115/June 2014

HMCTS failed to process defence and part admission in line with its procedures

When HMCTS failed to process Mr D's defence and part admission, it caused unnecessary court action. Although it recognised its error, HMCTS did not accept that it had caused Mr D the injustice he claimed.

What happened

Mr D had a claim issued against him. He submitted a defence and part admission to the court within the required time limit, but the court did not process this. Judgment was wrongly ordered in default against Mr D. After three months of court action, Mr D himself presented the claimant with his defence and part admission. This was accepted and a consent order was agreed between both parties on terms identical to those presented by Mr D in his original defence.

Mr D complained to HMCTS, who accepted it had made a mistake and offered to reimburse court fees of £80 and to pay Mr D £75 for the inconvenience caused. However, it maintained that Mr D had not suffered the level of injustice he was claiming and that the decisions on his case had been made by the judiciary.

What we found

If HMCTS had dealt correctly with Mr D's defence and part admission, matters could have been settled without the need for the court action.

HMCTS maintained, throughout its dealings with Mr D's complaint, that judicial decisions had determined the outcome of the claim made against him. It therefore did not accept that the injustice Mr D claimed could be linked to an administrative mistake by court staff. We disagreed: no judicial decision would have been necessary if the court had sent Mr D's defence and part admission to the claimant, as it should have. The matter would have essentially been settled out of court. While Mr D eventually got the outcome he wanted, getting to that point took almost three months, during which time he endured unnecessary court proceedings; incurred costs; had a County Court Judgment registered against him; had bailiffs attend his property; and had to communicate directly with the claimant in order to reach a settlement. After the case was concluded, he also spent time pursuing a justified complaint with HMCTS.

Putting it right

HMCTS accepted its mistake and apologised to Mr D for both the error and for not recognising sooner the impact of its actions on him. It also paid him £400 in recognition of the inconvenience and frustration suffered and for having to pursue a justified complaint.

Organisation we investigated

HM Courts and Tribunals Service (HMCTS)

Summary 116/June 2014

Delivered or not delivered?

HM Passport Office (HMPO) paid compensation to an applicant for a UK passport for its poor handling of his complaint about its failure to return valuable documents. But it could not be held responsible for the non-receipt of the supporting documents.

What happened

Mr V applied for a UK passport in summer 2011 using two Nigerian passports and his naturalisation certificate as supporting documents. HMPO said it delivered those documents by courier (for which Mr V paid a £3 fee) later in the year to Mr V's address, but as there was no reply, had put them through the letter box. Mr V insisted he had not received them. HMPO said the courier's handheld device recorded the date and time he called at the property by the use of GPS and the device also photographed the front door of the property, which Mr V confirmed was his door. HMPO was therefore satisfied it had delivered the documents correctly.

Mr V complained. He insisted he was at home at the time the courier put the documents through the letter box. HMPO did not investigate the circumstances as it relied entirely on the courier's handheld device indicating the courier was at the property. When Mr V's MP wrote to HMPO, HMPO asked the courier to return to the property (which Mr V had since vacated). A lady who said she lived at the property gave the courier information which conflicted with that given by Mr V. HMPO did not tell Mr V about this conflicting evidence or the police, to whom Mr V had reported the loss of his UK passport.

What we found

We partly upheld Mr V's complaint. The protective marking HMPO applied to passports and supporting documents was appropriate. HMPO's delivery policy complied with Information Assurance Standards and met the minimum requirements for delivery. HMPO did not correctly deliver Mr V's UK passport because it delivered it to his work address without getting his signature. However, we found a significant gap in HMPO's audit trail for the delivery of UK passports and supporting documents. HMPO's audit trail relies on the data from the courier's handheld device. The device does not prove whether the item was put through the letter box or wrongly taken by the courier. If the handheld device shows the courier was at the customer's door, HMPO does not recognise any other scenario than the documents being delivered. That was maladministration. Moreover, HMPO did not collect any data about such losses and so it could not satisfy itself that it had adequate measures in place to protect personal data (for example, passports) as required by the relevant Information Assurance Standard. HMPO did not properly investigate Mr V's complaint and did not respond flexibly to complaints such as Mr V's. HMPO had failed to retain documents in Mr V's case in line with its retention of documents policy.

We could not say that HMPO was responsible for Mr V's non-receipt of the documents. The effect of HMPO's maladministration was that Mr V was disempowered and disadvantaged because HMPO would not even recognise the possibility that his supporting documents had not been delivered, despite the fact it could not conclusively prove it had delivered the items. That further disadvantaged Mr V when he tried to recover them. HMPO compounded this by its poor handling of Mr V's complaint and we recognised the frustration and inconvenience this caused Mr V.

Our investigation was not helped by HMPO's failure to retain documents. Mr V was entitled to expect documents would be kept.

Putting it right

HMPO apologised to Mr V and paid him £500 compensation. It also agreed to review the data it gets to measure delivery performance, review how it handles complaints of non-receipt of documents and address the gap in the audit trail we identified.

Organisation we investigated

HM Passport Office (HMPO)

Summary 117/June 2014

Ofwat took too long to investigate complaint, then handled complaint about the delay poorly

Mr R complained to Ofwat about costs charged by his local water company for installing a new water supply. Ofwat took over two years to investigate the case.

What happened

Mr R complained to Ofwat about the time it was taking to deal with his case. When he complained to Ofwat it repeatedly failed to keep its promises and it did not answer his messages and emails. Mr R was unhappy that Ofwat did not provide a detailed response to his complaint or take any measures to improve its service. Ofwat refused to pay financial compensation to Mr R.

What we found

Ofwat reviewed its handling of Mr R's complaint when we told it we intended to investigate, and apologised to him for the time taken to deal with his case. Ofwat also reviewed its complaint process and told us that it intended to make changes to improve its complaint handling in future.

Ofwat had some resourcing issues that delayed its investigation of Mr R's case. It took some steps to address these issues but it did not tell Mr R the reasons for the delay or explain what action it had taken. Ofwat's response to Mr R's complaint was poor and it did not properly investigate his concerns and did not put things right for him. Ofwat's poor complaint handling caused Mr R a great deal of time and trouble and inconvenience.

Putting it right

Ofwat apologised to Mr R and paid him £250 compensation. It also told Mr R about the actions it will take to improve its complaint handling.

Organisation we investigated

Water Services Regulation Authority (Ofwat)

Healthcare cases

Summary 118/April 2014

Consultant wrongly told patient that she did not have cancer

Trust staff told Mrs C, following surgery, that she was suffering from cancer that would require treatment. Three weeks later, a surgical consultant told her that a preliminary histology report indicated that there was no evidence of cancer.

What happened

In summer 2012 Mrs C had surgery at the Trust. After the surgery, staff told her that she had cancer in her stomach lining and bowel. They told her that she would need cancer treatment and further tests, but they did not arrange these. Mrs C then saw a surgical consultant, who said that there was no cancer whatsoever.

Five weeks later the surgical consultant told Mrs C that she did in fact have cancer. He apologised and said that an amended histology report had arrived that now included the diagnosis of cancer. Urgent action was taken to refer Mrs C for chemotherapy, which began in autumn 2012.

What we found

The initial histology report that the surgical consultant saw before he told Mrs C that she did not have cancer said that cancer was present and that Mrs C needed treatment. It was apparent that the consultant did not read this report properly. However, our clinical adviser told us that the five-week delay in starting chemotherapy that this mistake caused would not have affected Mrs C's prognosis.

Putting it right

The Trust had already accepted that there had been a failing in the care provided by the surgical consultant and had made several improvements designed to avoid a similar occurrence in future. Both the Trust and the consultant had already apologised for the error made. We did not feel that there were any more changes the Trust could make but we recommended that it should pay compensation to Mr C, who had complained on behalf of his wife, for the distress caused by the incorrect information given to Mr and Mrs C. The Trust paid Mr C compensation of £1,200.

Organisation we investigated

Wirral University Teaching Hospital NHS Foundation Trust

Region

North West

City or county

Merseyside

Summary 119/April 2014

Patient with ectopic pregnancy lost her only fallopian tube

Doctors did not discuss all of the available options with Mrs G. She was therefore unable to make an informed decision about her treatment.

What happened

Mrs G had a known history of ectopic pregnancy. She began bleeding seven weeks into her pregnancy and went to A&E. The Trust felt that she should be treated conservatively (as some ectopic pregnancies, particularly if they are small, will die and be absorbed into the body). Staff did not discuss other options, such as medication and surgery, with Mrs G. She returned two days later and needed emergency surgery. Her remaining fallopian tube was removed, leaving her unable to conceive naturally. Mrs G said that, had she had the choice, she would have opted for medical intervention.

What we found

The Trust failed to discuss all available options with Mrs G and she was therefore unable to make an informed decision about her treatment.

If Mrs G had been offered her preferred treatment option of medical intervention, she would have had a 90% chance of avoiding surgery and therefore keeping her last fallopian tube. We could not say that Mrs G would have gone on to successfully conceive naturally because it is possible that the ectopic pregnancy would have damaged her tube; or that she would have gone on to have another ectopic pregnancy. However, if a tube had still been in place, she would have had an opportunity for natural conception, which she no longer has.

Mrs G had to cope with the distress of knowing that the outcome could have been different if she had been given a choice of treatment.

Putting it right

In recognition of the distress Mrs G suffered, we recommended that the Trust provide her with an open and honest acknowledgement and apology. We also recommended that the Trust pay Mrs G £5,000 compensation and produce an action plan to avoid something similar happening again.

Organisations we investigated

North West London Hospitals NHS Trust

Region

London

City or county

Greater London

Summary 120/April 2014

Trust failed to manage patient's labour pains adequately

When Mrs J went into labour, midwives failed to monitor her progress or make sure that the pain relief she was given was adequate.

What happened

Mrs J suffered from tocophobia (the fear of being pregnant or of giving birth) during her antenatal visits and she and Trust staff planned for her to have her baby by caesarean section. The day before she should have been admitted, she went into labour and arrived at the maternity unit when she was already 3cms dilated. It was confirmed she would have a caesarean section but her labour progressed very quickly and she gave birth naturally before a theatre was available.

What we found

We decided that the Trust appropriately classified Mrs J as a 'category 3' caesarean section. However, her care in labour could have been managed better. There was no evidence that she was either observed or monitored regularly, or that her gas and air pain relief was sufficiently helping her. There was also no evidence that staff considered her need for particular reassurance in the face of her known anxiety.

We also decided that even if staff had monitored Mrs J appropriately, it might not have been possible to carry out the caesarean section. However, her overall experience could have been better with more adequate pain relief and reassurance.

Putting it right

The Trust apologised and paid Mrs J compensation of £500. It put a plan in place to make sure these failings did not happen again.

Organisation we investigated

University Hospitals Coventry and Warwickshire NHS Trust

Region

West Midlands

City or county

West Midlands

Summary 121/April 2014

Trust failed to undertake thorough observations

A Trust did not record all of a patient's observations after surgery. The patient later died.

What happened

Mrs L was admitted to hospital for surgery to remove part of her lung. She was transferred to a 'step-down' area for her postoperative care but two days later she was found collapsed, and died. Her husband complained to the Trust, which accepted that it had not performed all of the necessary observations before Mrs L died. However, the Trust said that the recorded cause of death in the post mortem showed that the lack of observations had not contributed to her death. Mr L remained unhappy and asked us to investigate.

What we found

The Trust failed to perform two sets of standard observations and did not wake Mrs L to properly carry out the observations for the pain relief given to her. This was a failing. Despite this, the cause of death recorded in the post mortem report was unlikely to have caused any obvious symptoms, meaning that it was unlikely Mrs L's deterioration would have been spotted even if the observations had been performed correctly. However, we could not say for certain that this was the case. While the Trust had rightly acknowledged the missing observations, it had not given Mr L a clear apology for this.

Putting it right

We asked the Trust to apologise to Mr L and to share with him information about the changes put in place to make sure that it performed and documented all observations correctly.

Organisation we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Region

East

City or county

Essex

Summary 122/April 2014

Trust's handling of hospital discharge caused unnecessary distress

Ms C complained that although she asked about transport well in advance, staff at first refused to arrange transport for her to return home after she was discharged from hospital. Furthermore, Ms C complained that staff were rude during the incident.

What happened

Ms C was admitted to hospital in the spring of 2012 for an operation. Four days later she was declared medically fit for discharge and she asked for transport home (over 100 miles away). She said that the surgeon had agreed this when she met him before the operation. The Trust initially said no and told Ms C that she would have to find her own way home or would be discharged to a homeless shelter. It was later agreed that she was not fit to take public transport or to be sent to a homeless shelter. A taxi was arranged and took Ms C home.

What we found

There were a number of points when communication could have been better. As a result, the nursing staff did not know that Ms C expected to be given transport home. We could see that this put them in a difficult position. While this was stressful for the nursing staff, they failed to treat Ms C in a sensitive and dignified manner. There were also some shortcomings in the way that the Trust handled Ms C's complaint.

Putting it right

The Trust apologised to Ms C for the failings we identified. It acknowledged: shortcomings in communication in Ms C's appointments before the operation; failure to discuss discharge arrangements with Ms C before her discharge; mishandling of discussions with Ms C on the day of discharge, in particular it was inappropriate to suggest a discharge to a shelter before matters could be discussed with a doctor. The Trust also acknowledged that it could have handled the complaint in a more effective and customer-focused way."

Organisation we investigated

Cambridge University Hospitals NHS Foundation Trust

Region

East

City or county

Cambridgeshire

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 123/April 2014

Trust failed to diagnose injury after woman was taken to A&E by ambulance

Ms Q injured her sternum (breastbone) and spine, but she was sent home without either being diagnosed.

What happened

Ms Q was in a traffic accident. She was taken to A&E complaining of pain in her chest and neck. She was kept in overnight and discharged the following morning without any injuries being diagnosed. After two weeks, Ms Q went to another trust and had an operation for a fractured sternum. A year later, during a private medical examination, a fracture in her neck was diagnosed. Both injuries originated from the accident.

What we found

The Trust should have given Ms Q a CT scan, which would have diagnosed her injuries.

Putting it right

We recommended that the Trust apologise to Ms Q, pay her £2,000 and produce an action plan.

Organisation we investigated

Royal Surrey County NHS Foundation Trust

Region

South East

City or county

Surrey

Summary 124/April 2014

Trust failed to assess patient's risk of early heart attack and death

Mrs B complained that the hospital failed to carry out appropriate investigations to diagnose and treat her father's chest pain and told him he could fly when he was unfit to do so.

What happened

Mr A went to a GP with chest pains. The GP called an ambulance, which took him to the Trust's hospital. Doctors in A&E examined Mr A and carried out blood tests and an ECG (a test that records the rhythm and electrical activity of the heart). Mr A was admitted and given initial treatment for his condition. The next day a member of the on-call medical team saw Mr A. The doctor's plan was to discharge him and arrange an exercise tolerance test as an outpatient, but in the event the exercise tolerance test was performed before Mr A was discharged. An exercise tolerance test is an endurance test in which the patient walks or runs on a treadmill. It can help to diagnose ischaemic heart disease, which is the common cause of angina (narrowing of an artery supplying blood to the heart muscle) and other heart problems.

About a week after being discharged from the hospital, Mr A went abroad. While abroad he became ill and was admitted to a local hospital. Tests showed that he needed a triple heart bypass. However, while waiting for surgery, Mr A suffered a heart attack and a stroke. A heart bypass operation was performed, but Mr A died.

What we found

Doctors adequately assessed and treated Mr A's symptoms when he was admitted to the hospital. However, they subsequently got Mr A's diagnosis wrong. Mr A had unstable angina, but doctors decided that he had 'non-specific' chest pain. Doctors did not assess Mr A's risk of suffering an early heart attack and early death, as they should have done.

The Trust's own guidelines would have placed Mr A in the category of a medium or high-risk patient, but doctors decided that he was low-risk and arranged an exercise tolerance test, which was an inappropriate test. Doctors should have referred Mr A to a cardiologist, but this did not happen. Instead, they discharged him without reviewing his medication and without any follow up, other than a request to his GP to repeat the exercise tolerance test once Mr A had stopped taking one of his regular medications. Last, in line with guidance issued by the National Institute for Health and Care Excellence (NICE), Mr A should have been given information about his symptoms, the investigations and treatment doctors proposed, and about any lifestyle changes (including advice about foreign travel). But again this did not happen.

Our investigation concluded that Mr A had been denied any opportunity to make his own choices and to receive treatment that might have saved his life. We could not say on the balance of probabilities that Mr A would not have died but for the failings we had identified. But we recognised that the distress Mrs B suffered, and continues to suffer, will be compounded by the uncertainty of never knowing whether Mr A might have survived if doctors had identified the unstable nature of his condition, arranged the investigations and treatment he needed, and given him the information and advice he needed to know about his illness.

Putting it right

Following our report, the Trust agreed to acknowledge and apologise for its failings and put together an action plan that showed learning from its mistakes so that they would not happen again. It also agreed to pay Mrs B £2,000 by way of a tangible acknowledgement of the additional distress she and her family had suffered.

Organisation we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Region

North West

City or county

Blackpool

Summary 125/April 2014

Trust hospital provided appropriate care but did not keep proper records

Mrs Q was very upset that the Trust would not acknowledge that an appointment took place.

What happened

Mrs Q told us she attended an appointment with her father where the doctor and nurse told him his cancer had spread and his surgery would be cancelled. The Trust said that, according to its records, this appointment never took place.

What we found

We asked the Trust to speak to the staff who Mrs Q said were at this appointment, and the nurse found a record of it in her work calendar. The nurse said she thought the doctor had made a record of the appointment in Mrs Q's father's notes and he thought the nurse had done it.

Putting it right

We asked the Trust to apologise for its mistake and reminded it that it was important to keep accurate records.

Organisation we investigated

The Royal Marsden NHS Foundation Trust

Region

London

City or county

Greater London

Summary 126/April 2014

Trust failed to get consent for hernia surgery

When Mr P was admitted to have surgery for a hernia on one side of his groin, the Trust operated on hernias on both sides without getting his consent.

What happened

Mr P was admitted for a hernia repair to the right side of his groin, in spring 2012. His surgeon told him he also had a hernia on his left side and gave Mr P the consent form to sign. When Mr P woke after the surgery, he found that the surgeon had operated on both sides of his groin. Mr P continues to experience pain and discomfort on the left side of his groin.

What we found

We decided that the Trust did not get proper consent from Mr P to operate on both sides of his groin. We also decided that the Trust had not investigated Mr P's complaint reasonably.

Putting it right

We recommended that the Trust apologise to Mr P and pay him £3,000. We also recommended that the Trust should put an action plan in place to learn the lessons from the failings and make sure they didn't happen again. As the surgeon had left the Trust by the time of the complaint, we made a separate recommendation that he should also prepare an action plan to learn lessons from the failings.

Organisation we investigated

Royal Berkshire NHS Foundation Trust

Region

South East

City or county

Reading

Summary 127/April 2014

Poor complaint handling by GP provider

Very poor complaint handling by a GP practice manager was not adequately resolved by the parent company.

What happened

Mr C complained to a GP practice about difficulty obtaining an appointment for his mother, who has dementia, when she was ill. The response from the practice manager was rude and aggressive, and blamed Mr C for what had happened. Mr C came to us, and we contacted Malling Health as the parent company. Malling Health investigated and met Mr C to discuss his concerns. Mr C was not satisfied with the way Malling Health handled his complaint so he came back to us.

What we found

We considered that Malling Health had taken the complaint seriously, but we agreed with Mr C that it had not resolved his concerns adequately. This was because it had not provided a full and frank apology and explanation of what went wrong and it had not shown that it had learnt from the events Mr C complained about. This had caused Mr C further frustration and distress.

Putting it right

Malling Health wrote to Mr C to acknowledge the failings we identified, apologised, and explained how it would prevent similar issues from happening in future.

Organisation we investigated

Malling Health

Region

South West

City or county

North Somerset

Summary 128/April 2014

Trust displayed lack of urgency when treating patient

Mr F had a history of diabetes, severe kidney failure and other significant illnesses. He went to the Trust as an emergency with vomiting and bleeding and died the same day of sepsis.

What happened

When he arrived in A&E, Mr F was not properly triaged. Doctors had difficulty getting a vein to take blood samples. The delay in getting blood samples meant that there was a corresponding delay in diagnosing sepsis. Mr F was admitted to the high dependency unit, but deteriorated rapidly. The Trust did not consider that life support would be beneficial for him and he died about ten hours after arriving in A&E.

What we found

A doctor should have seen Mr F within ten minutes of his arrival at A&E (rather than an hour and 20 minutes later). Staff should have taken him to the resuscitation area, and used a different technique to get blood samples. Staff did not take blood samples until three hours and 40 minutes after Mr F's arrival. Although there were delays in caring for Mr F and diagnosing and treating his sepsis, we found that this made no difference to the eventual outcome.

Putting it right

We recommended that the Trust apologise to Mr F's wife who brought the complaint and produce an action plan to prevent it happening again.

Organisation we investigated

Northampton General Hospital NHS Trust

Region

East Midlands

City or county

Northamptonshire

Summary 129/April 2014

GP failed to take appropriate action when patient developed wound infection

Miss A, who had had surgery to repair a haemorrhage, developed an infection in the wound site.

What happened

Miss A received antibiotics from her GP practice and staff took a swab, which came back clear. There were delays in her follow-up appointment at the hospital because of administrative problems. When she went to the Practice more than two and a half months after her surgery, her wound had still not healed properly. She had by then received an appointment for an outpatient review at the hospital, for a date more than five weeks later.

The GP '*discussed concerns*' with Miss A and noted the date of the follow-up appointment. When Miss A attended the hospital, an infection was diagnosed in the wound site and she had to undergo further reconstructive surgery.

Miss A also complained about the treatment she received for an ear infection.

What we found

The GP failed to keep an adequate record of the consultation in question. There was no evidence that he examined the wound and he did not make any note of its condition. He failed to appreciate the severity of the situation, and he should have contacted the hospital consultant to arrange a review within the next few days. The failure to take action and the poor standard of record keeping were unacceptable.

The treatment Miss A received from the Practice for her ear infection was appropriate.

Putting it right

Following our report, the Practice wrote to Miss A apologising for the shortcomings we identified.

The Practice has conducted a significant event analysis to identify what learning it should take from this case. It will make sure that the GPs at the Practice review their communication and record keeping and that the GP discusses this complaint at his appraisal.

Organisation we investigated

A GP practice

Region

South West

City or county

Swindon

Summary 130/April 2014

Long wait in emergency department with no information and without appropriate nursing care

A man who attended the emergency department with a painful and swollen right ankle waited eight and a half hours to be reviewed by a specialist.

What happened

Mr L arrived at the Trust with swelling and pain in his right ankle. Trust records show that he was booked in and triaged late morning. He saw a junior doctor two hours later and blood tests were ordered. Mr L told us that he was seen around 8pm by a member of the orthopaedic team, who then went away to check his blood tests. Mr L then waited two more hours to be reviewed by another orthopaedic doctor. During that time he was not given any information about what was happening. He was offered one cup of tea and no food.

At around 10pm, when he started to feel faint, Mr L asked for something to eat and was offered food which he felt was not suitable for him for religious reasons. The specialist who eventually reviewed him confirmed a diagnosis of cellulitis and decided that he was to be discharged with oral antibiotics and painkillers. He was then discharged at around 11pm without any take-home medication, after the hospital pharmacy had closed. There was therefore a further significant delay before a family member could return to the hospital to get Mr L's medication. He was not given any help with calling a taxi.

What we found

The medical treatment Mr L received was reasonable, but it was unacceptable that he waited for such a long time before a decision-making member of the orthopaedic team saw him. He received no information about his treatment, diagnosis or management plan during his wait. The level of general nursing care he received was inadequate, because he should have been checked regularly, including being offered food, drink and painkillers. We concluded that the long delay could have been avoided if a consultant had reviewed Mr L in the emergency department. We also found that the Trust's response to the complaint was inadequate. We upheld the complaint.

Putting it right

The Trust has apologised to Mr L.

Organisation we investigated

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Region

North West

City or county

Merseyside

Summary 131/April 2014

Family left not knowing whether a woman would have fallen in hospital if nurses had properly assessed her

Mrs N's family complained about the care and treatment she received both before and after her fall. They wanted the Trust to recognise and apologise for its failings and to make changes to procedures.

What happened

Mrs N (who was in her eighties) collapsed at home and was admitted to her local hospital. Two nights later she was found on the floor beside her bed and told nurses she had fallen. The nurses asked for a doctor to attend but it took around six hours for this to happen. Mrs N was later found to have fractured the upper part of her left thigh bone. Mrs N had surgery to repair the fracture but she died two weeks afterwards.

Mrs N's family complained to the Trust about how the fall was allowed to happen. They said Mrs N had suffered from pain and discomfort because of a series of errors. The evidence shows that the Trust was aware of failings in care and treatment but it did not share this with Mrs N's family, even when they complained. A coroner's inquest was critical of the care and treatment and concluded that Mrs N would not have died on the day that she did '*but for the fracture*'.

What we found

The standard of care provided for Mrs N fell below the relevant standards for managing the risk of her falling and managing her pain. In addition, the Trust did not provide adequate responses to the family's complaint. It did not acknowledge failings that it had identified or tell them about the changes these had led to. It also failed to apologise for the failings, even after they had been highlighted during the coroner's inquest.

We could not say that Mrs N's death was avoidable but the risk of her falling and of her suffering an injury following a fall could have been reduced. She was also left in unnecessary pain. The family will never know whether Mrs N would not have fallen, or suffered the fracture, if her risk of falling had been properly managed. The Trust's poor complaint handling led to the family feeling that the Trust did not accept accountability for what had happened, and gave them the impression that their complaint had not been taken seriously.

Putting it right

The Trust has apologised for its failings and has paid the family £500 compensation. It has already taken steps to address the failings in care and treatment identified, and has produced an action plan in relation to the way that it handled this complaint.

Organisation we investigated

North Cumbria University Hospitals NHS Trust

Region

North West

City or county

Cumbria

Summary 132/April 2014

Trust should not have discharged patient from A&E

Trust staff inappropriately discharged Mr G from A&E. He returned to hospital shortly afterwards.

What happened

Mr G attended A&E with nausea, vomiting and not having opened his bowels for three days. Staff diagnosed him with constipation and discharged him. Mr G was admitted to hospital the following day and surgery found that he had a complete loss of blood supply to his small bowel.

What we found

The Trust inappropriately discharged Mr G from A&E after an inadequate clinical assessment by a junior doctor. Record keeping was not robust. We found that the care and treatment Mr G received during his admission was appropriate. Mr G's pain and his family's distress following his discharge from A&E would have been better managed by an admission, but the decision to discharge him did not affect the clinical outcome. Mr G also raised concerns about how the complaint was handled and we found a small number of shortcomings here.

Putting it right

The Trust completed an action plan to show that it has taken learning from this complaint.

Organisation we investigated

Bedford Hospital NHS Trust

Region

East

City or county

Bedford

Summary 133/April 2014

Trust failed to adequately meet needs of nursing mother

When Mrs W, a nursing mother, was admitted to the Trust, staff did not take appropriate action to meet her request to have her baby with her so she could continue breastfeeding.

What happened

Mrs W was the nursing mother of an eight-week-old baby when she was admitted to a general ward at the Trust. She was initially told her baby could not be with her on the ward. When she expressed milk and asked to store it in the ward fridge for her husband to take home, she was told she could not do this. The next day she was moved into a side room and told she could in fact have her baby with her.

What we found

The Trust gave Mrs W conflicting information about whether she and her baby could be together on the ward. Both the general ward and the post-natal ward missed opportunities to try to meet Mrs W's needs, and did not follow the Trust's breastfeeding policy. Mrs W was upset and angry because her breastfeeding was disrupted.

Putting it right

The Trust told us it had already taken steps to avoid such events happening again, which we welcomed. The Trust acknowledged and apologised for the failings, and also completed its work on updating its breastfeeding policy to cover giving support to nursing mothers who are admitted onto general wards.

Organisation we investigated

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Region

North Lincolnshire

City or county

Yorkshire and the Humber

Summary 134/April 2014

Trust did not give older patient adequate care

Ms J complained that the Trust wrongly discharged her father when he had a chest infection. She also complained about care and treatment during a later hospital admission. Ms J said the failings led to her father's death.

What happened

Mr J was in his late seventies and was the sole carer for his disabled wife. He had a history of heart disease and stroke. Mr J collapsed at home and was taken to hospital where doctors diagnosed that he had probably fainted. Doctors discharged him the following morning with outpatient follow up for his fainting episode.

Mr J became unwell about two weeks later. He went to hospital where doctors diagnosed that he had a chest infection. They gave him antibiotics and intravenous (into a vein) fluids. His condition deteriorated. Mr J developed pressure sores at the base of his spine, became unable to eat and drink, and required help to clear his airways. Staff were unable to insert a feeding tube to help feed Mr J. They inserted a central catheter, which ward staff were not trained to use. Mr J was moved to a different hospital shortly afterward. He sadly died several months later.

The Trust carried out a safeguarding investigation and found serious failings in the lack of food provided for Mr J during his second admission to hospital. The Trust did not find any other failings.

What we found

Several doctors saw Mr J during his first admission to hospital and carried out appropriate examinations of him. Their diagnosis, and the decision to discharge him, were reasonable and in line with established good practice. In terms of the second admission, there were no failings in Mr J's mouth care. However, the Trust did not give him adequate pressure area care, early physiotherapy intervention or adequate nutrition during his stay in hospital. While these failings were serious, we did not find that they led to Mr J's death. Finally, although ward staff did not know how to use the central catheter, the Trust promptly recognised this and tried to address it.

Putting it right

The Trust had already identified a number of improvements as part of the safeguarding investigation. We therefore recommended that it provide an update on the actions it has already agreed to undertake as part of the safeguarding investigation.

Organisation we investigated

Sheffield Teaching Hospitals NHS Foundation Trust

Region

Yorkshire and the Humber

City or county

South Yorkshire

Summary 135/April 2014

Patient's family let down by nurse's actions

A patient and his family were caused significant distress by a nurse's actions, despite good clinical care from Trust.

What happened

Mr P was suffering from a terminal brain tumour. He was admitted to hospital via A&E late in 2012 with difficulty breathing. During a transfer from a ward to one with a single room, there was a disagreement between a nurse and Mr P's family because the family were concerned that Mr P was not getting sufficient oxygen. Mr P was transferred and died later the same day. Mr P's family complained about the clinical and nursing care given to him. They also raised specific concerns about a particular nurse, including her attitude towards Mr P and his family, and that she did not provide Mr P with enough oxygen during a transfer from one ward to another.

What we found

The clinical care was of a high standard, but there were serious concerns about the actions of one of the nurses. When Mr P was to be transferred to another ward, there was insufficient oxygen in the cylinder and the nurse decided to reduce the oxygen flow rather than get another cylinder. As a consequence, Mr P struggled to breathe and when his family raised concerns with the nurse she refused to listen and dismissed their concerns. The records showed Mr P's oxygen levels dropped during this time, supporting the family's view that the reduced oxygen flow was causing him distress. Fortunately Mr P's oxygen saturation levels recovered once he was settled on the new ward and although he died shortly after, we did not find that the poor standard of nursing care was a contributory factor. The incident caused both Mr P and his family a considerable amount of unnecessary distress at an already very difficult time, given that Mr P was approaching the end of his life.

Putting it right

The Trust acknowledged the failings in nursing care and apologised to Mr P's family. It paid £1,000 in recognition of the distress and anxiety caused by the nurse's actions.

Organisation we investigated

Epsom and St Helier University Hospitals NHS Trust

Region

South East

City or county

Surrey

Summary 136/April 2014

Poor care and management of a patient with severe abdominal pain

Mrs D complained to us about the treatment her mother, Mrs R, received from the time of her admission until her death shortly after. Mrs D felt that the inadequate care her mother received removed any chance she had of surviving.

What happened

Mrs R was admitted to hospital with severe abdominal pain, abdominal swelling and vomiting. The following day, staff began a process to help raise Mrs R's extremely low blood pressure. Mrs R subsequently had emergency surgery to drain a large ovarian cyst. During this procedure, staff identified a perforated bowel, causing faecal peritonitis. After the surgery, Mrs R's prognosis was very poor and her condition continued to deteriorate. Despite intensive care, Mrs R sadly died soon after.

What we found

The medical team managed Mrs R's deteriorating condition inadequately for the first two days. Mrs R received insufficient fluids during this time. This was compounded by nursing staff's delay in refitting Mrs R's cannula.

Nursing staff miscalculated Mrs R's observation assessment scores one evening. If the scores had been properly calculated, this would have led to more frequent observations and an urgent medical review.

Mrs R was not seen by a consultant gynaecologist until early the next morning, despite a number of requests to attend.

Although we found significant failings in the care provided, it was not possible to say what the outcome might have been if staff had performed more frequent observations and started fluid resuscitation sooner.

We upheld the complaint.

Putting it right

The Trust acknowledged the failings identified in our report and apologised for the injustice it caused. It paid Mrs D £750 as compensation for the injustice we found and prepared an action plan that described what it did to make sure it had learnt lessons from the identified failings.

Organisation we investigated

Sherwood Forest Hospitals NHS Foundation Trust

Region

East Midlands

City or county

Nottingham

Summary 137/April 2014

Trust delayed performing a scan that would have detected kidney stones

We upheld this complaint about a delay in diagnosing extremely painful kidney stones.

What happened

Mr G complained about a delay in diagnosing kidney stones after he had been admitted to hospital as an emergency. He said that the Trust initially carried out an ultrasound scan, but this did not detect the stones. Staff gave him medication but he began to deteriorate and became extremely unwell. The Trust then performed a CT scan that detected the stones, after which Mr G was promptly treated.

Mr G said that if the Trust had carried out the CT scan at first, the stones would have been picked up and treated. He would have avoided the pain and anxiety he experienced before the Trust carried out the scan.

Mr G was annoyed by the way the Trust responded to his complaint because it did not accept that anything had gone wrong.

What we found

The Trust did not act in line with national guidance, which states that if kidney stones are suspected, as they were in Mr G's case, a CT scan should be carried out within 24 hours to confirm diagnosis. After Mr G's ultrasound came back clear, it was then a further two days before the Trust performed a CT scan.

Although Mr G was treated appropriately in the end, the wait for the CT scan was distressing and frustrating for him. He was also in a great deal of pain before the kidney stones were treated.

Putting it right

The Trust acknowledged what happened, apologised to Mr G, and paid him £250 in light of the distress caused. It prepared an action plan to show what it has learnt from Mr G's complaint, and how it will improve services for other patients in future.

Organisations we investigated

Isle of Wight NHS Trust

Region

South East

City or county

Isle of Wight

Summary 138/April 2014

Trust refused to arrange second opinion for cancer patient

The Trust refused to arrange a second opinion for Mr R after he was diagnosed with 'terminal' cancer and only offered him palliative chemotherapy (treatment to help symptoms rather than cure).

What happened

Following investigations at the Trust, staff gave Mr R a diagnosis of cancer and told him that it was inoperable. He was offered palliative chemotherapy. Mr R asked for a second opinion, but the Trust refused this. He says Trust staff told him it was pointless. Mr R managed to arrange a second opinion from a private hospital. After further tests, he was told that his condition was operable. Mr R returned to the Trust to request an operation, but the Trust asked for an additional test before agreeing to perform surgery. Mr R was unhappy with this and managed to arrange surgery at a different NHS hospital. The surgery was successful.

Mr R complained that the Trust incorrectly diagnosed his cancer as terminal and that it refused to arrange a second opinion. He also complained that the Trust refused to take the advice of the private hospital and declined to operate. He said that the Trust's actions caused him expense and inconvenience, and the thought of what would have happened if he had accepted the Trust's diagnosis and treatment plan has caused him considerable distress.

The Trust said that Mr R's presentation was unusual and concluded that its actions, based on the clinical findings at that stage, were appropriate. It also concluded that the further tests it requested before surgery was carried out were reasonable. The Trust agreed, however, to refund the £12,000 Mr R had paid for the second opinion at the private hospital. It declined to pay an additional £7,500 that Mr R asked for in recognition of the distress caused to him.

What we found

During our investigation, we took clinical advice from a specialist.

Based on Mr R's clinical presentation, the Trust's initial diagnosis and treatment plan were reasonable. We agreed with the Trust that Mr R's clinical presentation was very unusual and it would not be expected that his cancer would be operable. It was also appropriate for the Trust to request a further test before proceeding with surgery, because a scan showed that the cancer might still be in nodes that could have made surgery impossible. Fortunately for Mr R, his cancer was operable and his surgery was a success. However, the Trust's refusal to arrange a second opinion when Mr R asked for this was unreasonable. Additionally, the Trust did not adequately address this issue in its complaint response and we were not reassured that the Trust had adequate procedures in place for when patients requested a second opinion.

Putting it right

The Trust acknowledged the failings we identified and apologised to Mr R. It also paid Mr R a further £500 in recognition of the inconvenience and distress caused by the failings. In addition, it formulated an action plan to address the failings identified and make sure that appropriate procedures are in place for dealing with requests for a second opinion.

Organisation we investigated

Mid Essex Hospital Services NHS Trust

Region

East

City or county

Essex

Summary 139/April 2014

Patient removal from GP practice list was unreasonable

When a GP practice removed Mr P from its list, it failed to follow its policy and consider other options first.

What happened

Mr P attended a scheduled consultation with his GP for various minor complaints. During the consultation, Mr P became unhappy with the GP's response to his concerns, as the GP did not agree to conduct further tests or refer Mr P for other investigations. Mr P and the GP have differing accounts of what happened next, but both agree that the GP ended the consultation and Mr P left, raising a complaint with the Practice manager. Mr P says the GP was unreasonable in his refusal to conduct further tests and so he complained. The GP said Mr P showed aggressive and intimidating behaviour, putting him at significant risk of physical harm, therefore he decided to have Mr P removed from the Practice's list. This removal was relayed to Mr P at the end of the Practice's complaint response letter.

What we found

When we compared the actions of the GP and the Practice with the Practice's own policy on removing patients, we found that while accounts of events differ, there was no evidence in the records to suggest that Mr P acted in such a way as to have posed a significant threat of harm. The policy states that if this is the case, the police should be informed, and this did not happen.

Our investigation did not consider whether or not Mr P's behaviour was reasonable. It was clear, however, that the decision to remove him after this one incident, with no previous history of difficulty and without any specific information from the GP about exactly what was said or threatened, without talking to Mr P or giving him any warnings, and without any other steps, as set out in the policy, was unreasonable.

Putting it right

The Practice agreed to our three recommendations. It has reviewed its policy and all staff are aware of the steps that should be taken to conduct fair and reasonable patient removal or manage difficult patients. It has paid Mr P £150 for the inconvenience suffered by his removal. And it has apologised to Mr P and sent a copy to us and to the relevant clinical commissioning group.

Organisation we investigated

A GP practice

Region

London

City or county

Greater London

Summary 140/April 2014

Poor communication between staff and with patient led to loss of confidence in NHS care

Mrs D was recalled for an assessment in summer 2012. She complained about the clinical management of her diagnosis of breast cancer and her subsequent treatment from summer 2012 until winter 2013.

What happened

Following diagnosis, Mrs D underwent several rounds of surgery but did not have an MRI scan. She complained that: the Trust misdiagnosed her cancer; there was confusion about what sort of cancer she had; that she has not been given the most appropriate treatment for her cancer (including not being offered an MRI scan and being given inappropriate medication); and that there are inaccurate notes in her clinical records. She was concerned that, as a direct result of the way in which she was treated, her cancer had spread and was potentially terminal.

What we found

There were no failings in Mrs D's diagnosis or clinical care, and her breast cancer treatment was fully in line with clinical guidelines issued by the National Institute for Health and Care Excellence (NICE). However, there was poor communication between the health professionals and Mrs D and her family, and this confusion impeded how the Trust handled Mrs D's complaint. The poor communication has not directly affected Mrs D's care and treatment and clinical outcome, but it increased her anxiety when she was already concerned about her health, and contributed to her loss of confidence in the Trust.

Putting it right

The Trust prepared an action plan to remedy communications by its multidisciplinary team.

Organisation we investigated

The Rotherham NHS Foundation Trust

Region

Yorkshire and the Humber

City or county

South Yorkshire

Summary 141/April 2014

Clinical care of older woman was reasonable but there were some failures

Mr H complained that the Trust's clinical care and treatment of his mother were not of the standard that could be expected, and about the Trust's complaint handling.

What happened

Mrs H was in her early nineties when she was admitted to hospital with pain in her hip after a fall at home. She had a history of cardiovascular problems. Investigations revealed a slow heartbeat but no fracture. Staff noted a new diagnosis of anaemia, along with fluid overloading, a failing heart and low sodium. Ongoing care included a combination of medication adjustment to control blood pressure and heart failure, physiotherapy, and treatment for anaemia.

Just over a month after her admission to hospital, Mrs H collapsed on a hospital ward and sadly died two days later. The post mortem showed that she had died from a spontaneous intracerebral bleed, severe hypertension, myocardial infarction, congestive heart failure and anaemia.

What we found

Mrs H's clinical care and treatment were reasonable but the Trust had not reviewed its medicine reconciliation process, and had failed to discuss a do not attempt resuscitation (DNAR) order with Mr or Mrs H. There were some failings in the Trust's communication with Mr H and how it handled Mr H's complaint. While the Trust had apologised for this, we felt that there was more that could be done.

Putting it right

The Trust paid Mr H £250 in recognition of the stress and upset he suffered as a result of poor complaint handling.

We recommended that the Trust review its complaint handling in accordance with the Ombudsman's Principles of Good Complaint Handling and good practice. The Trust should pay particular attention to the Principle that organisations should deal with complaints promptly, avoiding unnecessary delay, and in line with published service standards where appropriate.

The Trust created an action plan that explained what it intended to do to minimise the risk of a failure to discuss resuscitation plans.

We recommended that the Trust review the efficiency of its medicine reconciliation processes to ensure the robust sharing of correct information about medication usage.

The Trust accepted our recommendations.

Organisation we investigated

The Mid Yorkshire Hospitals NHS Trust

Region

Yorkshire and the Humber

City or county

West Yorkshire

Summary 142/April 2014

Trust failed to alert district nurses to a risk of pressure sore

Staff were aware that Mrs F had developed a red area of skin on her bottom while she was in hospital. However, they did not tell the district nurses about this when Mrs F was discharged. Less than 24 hours after discharge, this turned into a pressure sore.

What happened

During an inpatient stay, Mrs F developed a red area of skin on her bottom that was at risk of becoming a pressure sore. Staff treated and monitored the area during admission. When Mrs F was due to be discharged from hospital into the care of the district nurses, staff sent a transfer form. However, the form did not refer to the red area of skin.

What we found

The red area should have been noted on the transfer of nursing care form in order to highlight this problem to the district nurses. We partly upheld the complaint because the Trust did not acknowledge this in its response and this was a failing.

However, in Mrs F's case, this failing did not have an impact. Highlighting the red area on the form would not have prompted an urgent visit from the district nurses and Mrs F developed the pressure sore less than 24 hours after discharge.

Putting it right

The Trust apologised to Mrs F's son.

Organisation we investigated

Dorset County Hospital NHS Foundation Trust

Region

South West

City or county

Dorset

Summary 143/April 2014

Trust did not monitor a biopsy properly

Mr C died following a liver biopsy. One of the risks associated with a liver biopsy is bleeding from the biopsy site.

What happened

After an outpatient appointment, Mr C's son tried to get his father a scan and follow-up appointment much sooner than the four months given by the Trust. Mr C went to A&E, but was sent home. He got a cancellation appointment for his scan, but the follow-up appointment remained months away. Mr C returned to A&E and was admitted. He was given a liver biopsy, but bled internally from the puncture site. He died two days after the biopsy.

What we found

The outpatient appointment did not provide an adequate care plan for Mr C. He should not have been discharged from A&E. Consent for the biopsy was not properly obtained and Mr C was not properly monitored and cared for after the biopsy. Mr C was given inappropriate medication after the biopsy and the Trust lost clinical records and two crucial scan images. The Trust's complaint handling was poor.

It was impossible to judge whether the biopsy was safe to proceed with, because of the missing records. We were unable to say if Mr C's death could have been avoided, but he was not given the best possible chance of surviving.

Putting it right

The Trust apologised, paid £500 for the poor complaint handling, and produced an action plan to prevent a recurrence.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Region

East

City or county

Essex

Summary 144/April 2014

Failings by hospital meant a patient became dehydrated

Mrs D's daughter, Mrs W, felt that her mother's admission to hospital had been delayed. She was concerned that her mother's subsequent dehydration in hospital affected her chances of survival.

What happened

Investigations had identified that Mrs D possibly had cancer. Her consultant at Sherwood Forest Hospitals NHS Foundation Trust (the first Trust) decided not to admit her to hospital but did not immediately write to Mrs D's GP while further investigations were performed. Mrs D remained unwell and was admitted to Nottingham University Hospitals NHS Trust (the second Trust) before all of the test results from the first Trust were known. The tests later confirmed that Mrs D had a type of abdominal cancer. While she was in hospital, she became dehydrated, and Mrs W complained about this and other aspects of her mother's care. Mrs D died in hospital six weeks later.

The first Trust apologised for delays in reporting on some of Mrs D's scan results. The second Trust apologised for allowing Mrs D to become dehydrated but said that the rest of her management had been appropriate. Mrs W remained unhappy and contacted us.

What we found

The first Trust: Mrs D should have been admitted to hospital when she was first seen or, at the very least, the Trust should have contacted her GP so that he had adequate information if Mrs D deteriorated. Mrs D's admission was delayed by ten days and while this had no bearing on the eventual outcome, investigations and treatment could have started sooner, avoiding additional distress for Mrs W and her family.

The second Trust: while much of Mrs D's management was reasonable, as the Trust said, it was a significant failing that she became dehydrated and needed dialysis. Although we found no evidence that this contributed to Mrs D's death or reduced her chances of undergoing surgery and/or chemotherapy, it undoubtedly caused a great deal of unnecessary distress to Mrs W and her family.

Putting it right

The first Trust apologised to Mrs W, reviewed its procedure for sharing significant information with GPs and paid her compensation of £500.

The second Trust paid Mrs W compensation of £1,000. Additionally, it created an action plan addressing the failings we identified and shared this with us, Mrs W, the Care Quality Commission and the local clinical commissioning group.

Organisations we investigated

Nottingham University Hospitals NHS Trust

Sherwood Forest Hospitals NHS Foundation Trust

Region

East Midlands

City or county

Nottinghamshire

Summary 145/April 2014

Trust's poor complaint handling fails to reassure

Failings in the Trust's complaint handling contributed to a lack of confidence that the clinical care it gave Mr H after his hip replacement surgery was appropriate.

What happened

Mr H had a total left hip replacement operation in late summer 2010. After the surgery, he experienced pain, which he described as being different to the pain he had felt after his right hip replacement. He had an X-ray and a scan, but these did not show any abnormalities.

Mr H was discharged from hospital nine days later. He then had physiotherapy and further investigations into the cause of his pain. An X-ray taken in early spring 2011 did not show any problems with the hip replacement. However, in summer 2011, following a further X-ray, it was identified that Mr H's hip replacement had become progressively loose. The Trust carried out surgery to put this right in autumn 2011.

Mr H considered that there were failings in the way the hip replacement surgery was performed and that the Trust should have identified the loosening of the hip replacement much sooner, given the pain that he had reported.

Mr H complained to the Trust, which took over four months to respond. Mr H was not happy with the Trust's response and sent a further letter to the Trust. The Trust took five months to arrange a meeting with Mr H and then a further month to send him a written response.

What we found

The hip replacement surgery was carried out appropriately. It is normal to experience a certain degree of pain following such procedures and the clinical examinations and investigations did not reveal that there was anything wrong with the hip replacement. We found that the first clinical sign that something was wrong was in summer 2011 and the subsequent treatment to put this right was appropriate and happened within a reasonable time frame.

However, the Trust's complaint handling was poor. We acknowledged that it can take time to arrange for staff to attend meetings, but there were excessive delays in this case. There was also no evidence that the Trust had kept Mr H informed about any delays or given any indication of when he could expect a response. The failings in the Trust's complaint handling were unlikely to have reassured Mr H about his clinical care.

Putting it right

The Trust acknowledged the failings in complaint handling and apologised for these. It paid Mr H £250 in recognition of the failings.

Organisation we investigated

United Lincolnshire Hospitals NHS Trust

Region

East Midlands

City or county

Lincolnshire

Summary 146/April 2014

Failings in A&E caused confusion about diagnosis

A woman wrongly believed she had hepatitis A after failings in A&E.

What happened

Mrs W had chronic lymphocytic leukaemia and was on antibiotics for a urinary tract infection. She felt very unwell and went to A&E. Blood test results were abnormal and the A&E doctor discussed next steps with the on-call medical specialist before discharging Mrs W with increased antibiotics and advice for her GP to repeat the blood tests in a week.

From what she was told in A&E, Mrs W believed she had hepatitis A and her GP accepted this information because he had not had any information about her A&E attendance when she visited a week later. After further tests and investigations, Mrs W was diagnosed with metastatic bone cancer three weeks later. No diagnosis was documented in the A&E record.

Mr and Mrs W complained to the Trust about the misdiagnosis of hepatitis A and that staff did not document it or report it to her GP. They also complained that the Trust did not do enough to investigate and treat her symptoms. They said the failings in care delayed the eventual diagnosis and Mrs W's pain worsened during this period.

The Trust acknowledged and apologised for not providing pain relief. It also acknowledged that the information given to the GP should have been clearer. It outlined steps taken to address these issues. It apologised *if* Mrs W had been given misleading clinical information, but there was nothing in the records about hepatitis A. It said it was not uncommon to discharge patients without a diagnosis if none could be found.

What we found

Overall, the assessment and the decision to discharge Mrs W back to the GP (as documented in the records) were reasonable. However, the Trust should have carried out a urine test and should not have increased the antibiotics without a urine test. These failings did not affect the outcome in this case.

We did not find, on the available evidence, that there were failings in diagnosis and documentation in relation to hepatitis. However, failings in communication resulted in Mr and Mrs W's belief that the Trust had diagnosed hepatitis. This affected subsequent consultations with the GP and may have resulted in a small delay in carrying out further tests.

The A&E doctor should have made a discharge diagnosis.

The system for reporting A&E attendances to GPs was not robust, but we were unable to conclude that the Trust was responsible for Mrs W's GP not receiving the report.

Putting it right

The Trust implemented a new system that allowed typed summaries to be sent to GPs electronically. It also changed the way A&E staff prepared GP reports, to increase clarity. These steps were implemented before we completed our investigation. This systemic action will reduce the likelihood of a recurrence.

The Trust took appropriate steps to address the matter of pain relief with staff and apologised that Mrs W was not given pain relief. This was reasonable and we did not recommend any further action.

The Trust will write to Mr W to acknowledge the failing in communication and that a discharge diagnosis should have been made in this case. The Trust will take our feedback that medical staff should be encouraged to make discharge diagnoses as a learning point.

Organisation we investigated

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

Region

South East

City or county

Buckinghamshire

Summary 147/April 2014

Poor management of a patient with a breast lump

Mrs P complained that her GP, Dr M, inaccurately diagnosed a lump on her right breast as benign in spring 2013. Unhappy with that diagnosis, Mrs P sought a second opinion from a different GP at the Practice. This led to a hospital referral, which resulted in scans that, in summer 2013, identified breast cancer. Mrs P was concerned that the months between the original assessment and the referral may have been detrimental to her health.

What happened

Dr M noted a mobile lump the size of a 20 pence piece on Mrs P's right breast in spring 2013. Mrs P subsequently met Dr M again to discuss another, unrelated, matter. Dr M did not re-examine the lump on Mrs P's breast at this appointment and Mrs P did not raise it as an issue of ongoing concern. In early summer, Mrs P returned to the Practice and was seen by a different doctor, who made a referral to the breast clinic. Some weeks later, the breast clinic diagnosed breast cancer. Mrs P had a mastectomy and began chemotherapy treatment in late summer 2013.

What we found

The management plan in the GP records, to review in one month after the first consultation, was appropriate and in line with National Institute for Health and Care Excellence (NICE) guidance. However, on the balance of probabilities, we considered that Dr M did not communicate this management plan clearly to Mrs P.

Despite documenting, after the first consultation, that the plan was to review the lump in a month's time, Dr M did not go back over the consultation notes or carry out a review.

There were failings in communication and the care provided. However, we felt it was highly likely that Mrs P would have had the treatment she received after the referral in summer, even if she had received appropriate care and been referred sooner.

We partly upheld the complaint.

Putting it right

The Practice reviewed the findings of our investigation report and confirmed to Mrs P and us the actions it planned to take to prevent similar failures of care in the future. We advised the Practice to consider our clinical adviser's view that it may be appropriate to arrange to see all patients with a breast lump in four weeks' time, even if the GP strongly suspects that the lump is benign

Organisation we investigated

A GP practice

Region

London

City or county

Greater London

Summary 148/April 2014

Inadequate communication with patient with colonic cancer

Mr M was treated at the Trust for colonic cancer. His wife complained about shortcomings in the treatment and surveillance of his disease, which contributed to his death.

What happened

Mr M had surgery at the Trust to remove a cancerous tumour. The pathology report suggested that its removal may not have been complete and several years later another tumour was identified.

Mrs M asked us to investigate a number of issues relating to Mr M's treatment. She felt that the Trust had missed a number of opportunities to identify and treat her husband's cancer.

What we found

While the removal of Mr M's tumour could theoretically be classified as 'incomplete', there was no evidence that this was the case, because the follow-up surveillance, which complied with the cancer guidelines then in force, failed to identify any further tumour for almost four years.

However, communication with Mr M regarding further treatment options was inadequate.

Putting it right

The Trust has acknowledged and apologised for the poor communication with Mr M.

Organisation we investigated

Airedale NHS Foundation Trust

Region

Yorkshire and the Humber

City or county

West Yorkshire

Summary 149/April 2014

Trust failed to get adequate consent for surgery

Mr S underwent routine surgery but there were a number of complications.

What happened

Mr S had surgery on his wrist at Weston Area Health NHS Trust. This resulted in damage to nerves. He has since suffered worsening pain, which has spread along his arm.

What we found

The complications that Mr S encountered have been unusually serious, although nerve damage is a known complication. Despite this, there is no record that Mr S was advised of this possible outcome. We would have expected this to be included on the consent form that he signed prior to surgery.

We did not find any shortcomings in the treatment or follow-up measures that the Trust put in place to reduce the impact of the nerve damage on Mr S.

Putting it right

Following our report, the Trust acknowledged and apologised for its failings.

Organisation we investigated

Weston Area Health NHS Trust

Region

South West

City or county

North Somerset

Summary 150/April 2014

Trust learns from complaint about poor nursing care

Mrs N complained about the quality of nursing care her mother received in hospital.

What happened

Mrs N complained that nurses did not care for her mother properly in hospital. She was not encouraged to eat and drink properly and lost weight. She was also not kept comfortable in her bed, and on one occasion Mrs N found her in her own excrement. Mrs N also complained that staff seemed too busy to speak to her and she was not kept up-to-date about her mother's condition.

The Trust recognised some failings in its nursing care and communication. It apologised to Mrs N and said it had spoken to staff about this and had recruited more nurses. Mrs N told us that although the Trust had given her some reassurances, she did not think that anything would change.

Mrs N also complained that the Trust sent a letter containing sensitive information about her complaint to the wrong address. The Trust said it had reported this in line with its policy and Royal Mail had told it that the letter would be returned to it.

What we found

Some of the nursing care was poor. We saw that the Trust had already taken some steps to improve this. However, we thought it needed to do more to address Mrs N's complaint that her mother was not encouraged to eat and drink properly.

The letter was not returned and we do not know what happened to it. The Trust told us it has started putting return delivery stickers on all of its letters to help stop this happening again.

Putting it right

We asked the Trust to prove what action it had already taken, which it did. We reassured Mrs N about this. We told her the Trust had started a campaign to improve how nurses looked after patients' food and drink needs. We also told Mrs N that the Trust had started using return delivery stickers.

Organisation we investigated

County Durham and Darlington NHS Foundation Trust

Region

North East

City or county

Darlington

Summary 151/May 2014

Dentist ground tooth too far

Mrs A complained about the dental treatment that she received when she was given a crown, particularly that one of her opposing teeth was ground down too far.

What happened

Mrs A had a crown fitted because she had a broken tooth. She complained that the dentist ground down the tooth opposing the one that she was having treatment on. She was concerned that this was unnecessary, and that it caused her pain and sensitivity.

What we found

Although it was appropriate that the opposing tooth was ground down, we found that, on the balance of probabilities, the dentist removed too much enamel from Mrs A's tooth. This resulted in the problems with this tooth that she described.

Putting it right

The dental surgery acknowledged that a dentist removed too much enamel when grinding down the tooth opposing Mrs A's crown, and apologised. The dental surgery paid her £200 in recognition of the distress she experienced. It produced an action plan documenting how it will learn from what happened and what it will do to prevent the same thing happening again.

Organisation we investigated

A dental surgery

Region

South East

City or county

Portsmouth

Summary 152/May 2014

Patient in mental hospital was not adequately assessed in A&E

A man who was detained in a high-secure mental hospital was taken to A&E at a general hospital. Staff there failed to adequately assess him and he was discharged. He was brought back later that evening, admitted to intensive care, and died a few weeks later.

What happened

Mr D, who was in his thirties, lived in a high-secure psychiatric hospital. Staff were concerned about a knee injury and other signs of a worsening physical illness. They took him to A&E at the nearby general hospital, where he was seen by a nurse and a doctor. He was diagnosed with soft tissue injury and discharged. Staff at the high-secure hospital continued to be concerned by Mr D's condition and later that evening, took him back to A&E. This time he was admitted to intensive care, but died three weeks later of a serious infection.

The patient's aunt, Mrs E, complained to the Trust in summer 2011, saying that she was concerned that failures might have contributed to her nephew's death. At first, the Trust refused to respond to her complaint, because it did not have permission from Mr D's next of kin. The Trust eventually responded to her complaint in summer 2013.

What we found

The Trust failed to assess Mr D when he first presented to A&E. Although we did not find that this failure contributed to Mr D's death, it caused distress to him and his family. Although Mr D was given appropriate care and treatment when he returned, the Trust failed to take action to address the earlier mistake.

Furthermore, there was maladministration in the Trust's handling of Mrs E's complaint. It was unreasonable to insist that Mr D's next of kin needed to give permission to investigate the complaint. Even after the Trust accepted this was wrong, there was an unreasonable delay in responding to Mrs E.

Putting it right

The Trust agreed to acknowledge and apologise to Mrs E for the poor service her nephew received and for failing to take reasonable action when the problem became apparent. It also agreed either to explain to Mrs E the service improvements that had taken place since the events or to prepare an action plan to stop the failings happening again.

The Trust also agreed to pay Mrs E £500 for the poor handling of her complaint.

Organisation we investigated

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Region

Yorkshire and the Humber

City or county

South Yorkshire

Summary 153/May 2014

Lost records prevented full understanding of patient care

The loss of vital medical and nursing records prevented a family understanding if their mother's death could have been avoided.

What happened

Mrs Z was admitted to hospital with a suspected small bowel obstruction. She was initially treated conservatively. However, within three days of admission, her health deteriorated overnight. Urgent surgery, carried out the following morning, identified and repaired a rupture in Mrs Z's bowel, but she continued to deteriorate. She died about a week later.

What we found

Initial conservative treatment was appropriate and in line with the standards and guidelines for the management of small bowel obstruction. However, due to the loss of vital medical and nursing records, particularly relating to the period when Mrs Z's health began to deteriorate, we were unable to say whether or not the treatment given at the point of deterioration was appropriate, or if the Trust should have performed surgery earlier. We found the loss of the records denied Mrs Z's family the opportunity of knowing, through the complaints process, whether everything that could have been done was done, or if the outcome could have been different.

Putting it right

The Trust fully accepted our recommendations and paid Mrs Z's family £500 to recognise the lost opportunity to know what happened to their mother. It also created an action plan to detail the improvements it would make in record keeping.

Organisation we investigated

North Cumbria University Hospitals NHS Trust

Region

North West

City or county

Cumbria

Summary 154/May 2014

Care and treatment of patient with complex health needs was reasonable

Mrs D complained to us about the care her mother, Mrs R, received during her stay in a psychiatric unit in spring 2011. She was unhappy with the discharge planning arrangements and the care Mrs R received in the community after her discharge.

What happened

Mrs R had a history of physical health problems as well as mental health difficulties. Her mental health deteriorated significantly in spring 2011 and she voluntarily agreed to be admitted for psychiatric care. She went into a psychiatric unit until her physical health deteriorated and she was transferred to an acute hospital for further treatment the next month. Mrs R was given treatment for fluid retention and she was subsequently discharged home.

As well as complaining to us about her mother's care, the discharge planning arrangements and the care she received in the community afterwards, Mrs D also complained about the way the GP Practice managed the various painkillers and other prescription drugs her mother was taking and the apparent effect these were having on her mother's deteriorating mental health.

Mrs D was also unhappy about how the Trust and the Practice handled her complaint.

What we found

The care and treatment provided to Mrs R was, on the whole, of a reasonable standard. However, the way the complaint was handled, particularly by the Practice, was poor. This led to an injustice that was not recognised or remedied, leaving Mrs D frustrated and confused about the complaints procedure. In addition, she was distressed by the delays she encountered during this process.

We partly upheld the complaint.

Putting it right

We recommended that the Trust and the Practice should apologise to Mrs D for the way they handled her complaint and send us evidence that lessons have been learnt about this. We also recommended that the Practice should pay Mrs D £500 as compensation for the injustice we have found.

Organisations we investigated

5 Boroughs Partnership NHS Foundation Trust

A GP practice

Region

North West

City or county

Merseyside

Summary 155/May 2014

Consultant failed to follow established clinical practice and the GMC's *Good Medical Practice*

Mrs C complained about the way a consultant psychiatrist conducted an appointment with her daughter.

What happened

Mrs C's daughter was referred to the Trust for an appointment with a consultant psychiatrist. Both Mrs C and her daughter attended this appointment. Following this, Mrs C's daughter's mental health deteriorated.

What we found

The consultant's actions fell below the expected standard and were not in accordance with established good clinical practice and the General Medical Council's publication *Good Medical Practice*. There was: a failure to undertake a robust assessment with a management plan; a lack of engagement; a failure to engage the multidisciplinary team; and the patient was given inappropriate advice. We upheld the complaint.

Putting it right

The Trust arranged a face-to-face apology with the consultant psychiatrist.

We also recommended a written apology and that the Trust put together an action plan to address the identified failings.

Organisation we investigated

Sussex Partnership NHS Trust

Region

South East

City or county

West Sussex

Summary 156/May 2014

No evidence that dental hospital received faxed referral letters

Mr L's dentist agreed to refer him to the Trust's dental hospital for treatment. The dentist's records indicated that the dental practice faxed the referral to the Trust in late 2012.

What happened

Mr L waited two months but heard nothing from the Trust. He visited the dental hospital and staff gave him the fax number to which dentists should send referrals. Mr L gave this number to his dentist to re-fax his referral.

Mr L waited another month but the Trust did not contact him. He then arranged for his dentist to fax the two referral letters to his place of work. Mr L delivered them to the dental hospital and subsequently obtained his appointments.

Mr L complained to the Trust about the inadequate management of his referrals, which caused him to suffer for longer than was necessary.

The Trust said that there was no evidence of any faxed referrals made for Mr L. It added that it had checked that its fax machines were working and had received other patient referrals at this time.

Mr L was dissatisfied with this response and complained to us. He wanted acknowledgements and an apology.

What we found

The Trust provided an appropriate response to Mr L's concerns. There was no evidence that it had received the faxed referral letters. Therefore, the delay in booking Mr L's appointments was outside its control.

We did not uphold the complaint.

Organisation we investigated

Birmingham Community Healthcare NHS Trust

Region

West Midlands

City or county

West Midlands

Summary 157/May 2014

Poor nutritional care given to patient in nursing home

Mr K had a stroke in spring 2009. After his discharge from hospital, he received NHS-funded continuing health care and was discharged to the nursing home. In early summer 2012, his partner Ms L complained about the removal of possessions from Mr K's room and suggested that the change in layout of the room was not in his best interest. Ms L was subsequently told to stop visiting. After she complained about this, Ms L was allowed limited visits but restrictions were imposed and her contact with Mr K was supervised by members of staff.

What happened

A safeguarding referral was made in summer 2012 because Ms L was concerned that her exclusion was affecting Mr K's care. She was also concerned that her exclusion, the removal of certain items and the change of layout of Mr K's room were having a detrimental effect on his quality of life.

The safeguarding investigation concluded that the nursing home had provided no evidence that the actions taken were in Mr K's best interest and advised that they should be cancelled with immediate effect. It was also later concluded that the restrictions of contact imposed on Ms L, the change in the room layout, and the removal of possessions were unlawful within the framework of the *Mental Capacity Act 2005* and should be lifted with immediate effect. Ms L said that despite these findings, it took the nursing home several months to comply with the safeguarding advice.

Ms L said that the restrictions imposed meant she was escorted at all times, which did not allow her and Mr K any privacy. She said that Mr K's health deteriorated as a result of the imposed sanctions. She was particularly concerned about Mr K's weight loss in the weeks and months prior to his death. Ms L was previously allowed to feed Mr K but this involvement was denied to her while these restrictions were in place.

Ms L was concerned that the nursing home had not apologised for its failings and displayed no learning or understanding of the suffering she and Mr K endured. She also said that there was no cascading of training and no evidence of better compliance with external authorities right up to mid-2013, when Mr K died.

What we found

Neither the Primary Care Trust (PCT) nor the Clinical Commissioning Group (CCG) considered fully Ms L's complaint about the nursing home.

Mr K received poor nutritional care in the six months prior to early 2013. However, there was no evidence that his weight loss compromised his overall health prior to his death.

It took the nursing home several months to comply fully with the findings and recommendations of the safeguarding investigation. We considered this poor service. The nursing home noted in internal documentation that it handled this situation poorly. However, it did not communicate this to Ms L or formally apologise to her. Nor did it apologise for the time it took to comply with the safeguarding recommendations.

We upheld the complaint.

Putting it right

We recommended the CCG should apologise to Ms L for the way the PCT and the CCG handled her complaint. We also recommended that the CCG should confirm what actions it planned to take to prevent similar instances of poor complaint handling in the future.

We recommended that the nursing home should apologise to Ms L for: its failure to initially recognise and manage Mr K's low weight in the six months prior to early 2013; the way it excluded Ms L from the home between summer 2012 until early 2013; the poor nutritional care given to Mr K during this period; and for the detrimental impact Ms L's exclusion had on her and Mr K's relationship and their quality of life; the way it deprived Mr K and Ms L of each other's company and his possessions; the way the nursing home changed the layout of Mr K's room; the time it took to put things back to the way they were and for the negative affect this had on his quality of life.

We also recommended that the nursing home should confirm what actions it plans to take to prevent similar instances of poor complaint handling in the future.

Organisations we investigated

A nursing home

Bath and North East Somerset Clinical Commissioning Group

Region

South West

City or county

North Somerset

Summary/158 May 2014

Hospital made mistakes, leaving baby with brain damage

A one-day-old baby suffered permanent brain damage because a nurse and two doctors made serious mistakes during a blood transfusion.

What happened

Baby F was one day old when she developed severe jaundice that worsened quickly and needed urgent treatment involving a blood transfusion. A doctor and a nurse carried out the transfusion while a more senior doctor supervised the procedure. During the transfusion, the baby's condition deteriorated quickly and she suffered a collapse. Her heart stopped and she had problems breathing. The collapse caused permanent brain damage and Baby F is not developing normally. She will have disabilities and will need care for the rest of her life.

What we found

The nurse and doctor conducting the transfusion made serious mistakes. The doctor supervising the transfusion also made serious mistakes when Baby F's condition started to deteriorate. As a result, they took out far more blood than they put in. They should have kept an equal balance. These mistakes led to Baby F's collapse and the brain damage she had afterwards.

Putting it right

Following our investigation, the Trust acknowledged the mistakes it made in Baby F's care and the consequences they had. It wrote to Mrs F to accept its failures and apologise for them. It also agreed to carry out a root cause analysis to find out why the failures in this case happened, and to take action to make sure they never happen again.

Organisation we investigated

Barts Health NHS Trust

Region

London

City or county

Greater London

Summary 159/May 2014

Impact of significant delays between hospital review appointments

Mr A had a history of facial pain and was referred to the maxillofacial (jaws and face) department.

What happened

The consultant, Mr B, saw Mr A, and an MRI scan was carried out two months later. Mr A was not able to get a prompt review with Mr B and paid to see him privately for the results of the scan. Mr B made an initial diagnosis of facial migraine and unusual facial pain. Following a further extensive delay in the next appointment with Mr B, Mr A's GP referred him to a neurologist, who diagnosed cluster headaches.

Mr A complained about the delays and that he felt compelled to see the consultant on a private basis, which cost him money. He also complained that Mr B did not diagnose his cluster headaches and prescribed medication that made his symptoms worse.

Mr A said that appropriate treatment was delayed and this left him in extreme pain. Mr A also complained about how the Trust handled his complaint and delays.

What we found

The treatment provided was mainly reasonable. Although the delays between review appointments were unacceptable, we could not know what might have happened if more timely review appointments had been arranged. However, there was a missed opportunity for Mr B to explore the initial diagnosis and to make an earlier referral for Mr A to a specialty where he has now received help.

The key issue was the delay in review appointments, which was completely outside Mr B's control. Complaint handling was also poor. The Trust had acknowledged this but we found that the Trust's actions did not go far enough to remedy the injustice to Mr A.

Putting it right

The Trust apologised further to Mr A and paid him a total of £1,400, including £150 to reimburse the cost of the private fee and £250 for poor complaint handling. The Trust complied with our recommendations.

Organisation we investigated

East Kent Hospitals University NHS Foundation Trust

Region

South East

City or county

Kent

Summary 160/May 2014

Poor pain management

Mrs D complained on behalf of her late mother, Mrs T. She complained about pain management and the administration of sedatives. We partly upheld her complaint.

What happened

Mrs T suffered a bleed while in hospital. Trust staff decided to manage her condition conservatively. Unfortunately she deteriorated and she was discharged to a nursing home, where she died.

What we found

We found that there was a delay in managing Mrs T's pain following the bleed. As a result, she was in pain for longer than she should have been. Mrs D witnessed this. The Trust had not taken action to put this right.

We found that the Trust managed the prescription and administration of sedatives properly.

Putting it right

The Trust apologised; paid Mrs D £350 and drew up an action plan.

Organisation we investigated

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Region

South West

City or county

Bournemouth

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 161/ May 2014

Trust failed to properly answer a justified complaint

Following a diagnosis of deep vein thrombosis, Ms E's haemoglobin levels were not monitored and she became so anaemic that she had to undergo a blood transfusion at the Trust.

What happened

When Ms E complained to the Trust, it told her that it thought her GP was monitoring her haemoglobin levels and it did not acknowledge that it should have checked her levels at some point. The Trust also failed to address Ms E's concerns about her hospital stay in any detail, missed the point of her complaint and gave incorrect information.

What we found

The Trust did not deal adequately with Ms E's justifiable complaint about its services. We could not say conclusively that Ms E's hospital admission could have been avoided if the Trust had acted differently, but the care given was not as good as it could have been.

Putting it right

The Trust acknowledged that the care provided was not as good as it should have been, apologised, and reviewed its policies and processes to improve care.

Organisation we investigated

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Region

North West

City or county

Merseyside

Summary 162/May 2014

Some failings in response to calls for an ambulance and subsequent complaint handling

Ms J complained about two separate incidents during which there were delays in receiving an ambulance response from the East Midlands Ambulance Service NHS Trust.

What happened

The calls for an ambulance were made on behalf of Ms J's now deceased mother. Ms J complained that during both incidents the ambulance response from the Trust was too long. Ms J was unhappy with the Trust's response to her complaint.

Ms J wanted the Trust to acknowledge the impact of the delays, learn from its mistakes and compensate her for the grief it caused and its complaint handling.

What we found

There were procedural failings in the first incident. We were unable, however, to conclude that the failings led to a delay in the ambulance response time. The Trust has since made suitable improvements, but it has not told all relevant members of staff about them. The Trust's response to this part of Ms J's complaint was reasonable.

There were some failings in the second incident. While there were failings in the procedures followed, we were unable to conclude that the failings resulted in a delayed ambulance response. We found that there were failings in the Trust's complaint handling.

We partly upheld the complaint.

Putting it right

Following our report, the Trust apologised to Ms J for the failings in the second incident and the failures in complaint handling. The Trust agreed to prepare an action plan to make sure that the failings identified are not repeated.

Organisation we investigated

East Midlands Ambulance Service NHS Trust

Region

East Midlands

City or county

Nottingham

Summary 163/ May 2014

Trust did not have all relevant information when it decided to discharge patient

Mrs B had been under the care of the ear, nose and throat department for several years because of ear problems. She had surgery that appeared to be uneventful but she was then admitted to hospital with an ear infection.

What happened

Mrs B was in hospital for five days to receive antibiotics and treatment for her infection. Staff planned to follow her up one week later but Mrs B was readmitted to hospital the following day. Sadly one month later she died.

Mrs B's daughter complained that Mrs B received poor nursing care during her first admission, including lack of food and fluids, and that her mother's regular medications were not prescribed for her when she was in hospital. She also complained about the decision to discharge her mother when she was still unwell.

What we found

The nursing care provided could have been better but the Trust had already acknowledged this and had apologised and made improvements. However, the decision to discharge Mrs B was not based on complete information. There was no record that Mrs B had vomited and the hospital had prescribed some strong medication for this. This called into question the decision to discharge Mrs B. The Trust did not identify this failing during its investigation of the complaint.

Mrs B's daughter thought that her mother might not have died if the care had been better. Although Mrs B was dehydrated when she was readmitted to hospital, this was quickly sorted out and we did not think that any failings at discharge from the first admission led to Mrs B's death one month later.

Putting it right

The Trust acknowledged the failings identified and apologised for them. It paid Mrs B's daughter £1,000 as an acknowledgement of the failings during Mrs B's first hospital admission, the distress and anxiety caused to Mrs B and her family, and the failure to provide a full response to the complaint.

Organisation we investigated

University Hospitals Bristol NHS Foundation Trust

Region

South West

City or county

Bristol

Summary 164/May 2014

Trust failed to properly manage patient's pain, and gave incorrect information in complaint response

When Mr T was admitted to hospital, his pain was not managed as well as it should have been.

What happened

Mr T was admitted to hospital with back pain while the Trust managed his pain and planned his treatment.

Mr T complained that the Trust did not properly manage his pain during his whole admission, and that it falsified his records and gave wrong information in the complaint response.

What we found

The Trust did not give proper pain relief for a short period of time. The rest of the time it tried to the best of its ability to manage Mr T's pain, but it had not been possible to eradicate it. We found that the Trust had properly admitted the failings and had apologised, but had not explained what action it would take to prevent the same thing happening again.

We found no evidence the Trust falsified Mr T's records, but we found that it had mixed up two different hospital attendances and so gave wrong information in the complaint response.

Putting it right

The Trust accepted our findings and drew up an action plan that showed how it would stop something similar happening again. The Trust also apologised to Mr T for giving incorrect information in its complaint response.

Organisation we investigated

The Dudley Group NHS Foundation Trust

Region

West Midlands

City or county

West Midlands

Summary 165/May 2014

Poor communication meant that family did not get chance to say goodbye before mother died

When an older patient died unexpectedly, her family complained about whether her illness could have been treated sooner.

What happened

Mrs M was admitted to hospital after collapsing at home. She had been suffering from diarrhoea and her GP had diagnosed an infection in her intestines. While in hospital, Mrs M's condition remained stable and doctors saw her regularly. Mrs M then had abdominal pain. An X-ray showed she was constipated. When Mrs L visited her mother the next day, she found she was very unwell. This was over a bank holiday weekend and Mrs L was concerned about staff levels on the ward. Doctors decided that while staff would provide active care for Mrs M, there would be no intervention if her condition worsened. The family agreed with this decision. Mrs M died later that evening. A post mortem found that she had died from peritonitis following the infection in her intestines.

What we found

The Trust had accepted there was a problem with staffing on the ward, but Mrs M had been regularly reviewed by nurses and doctors. There was no evidence that her deterioration should have been noticed sooner, and her care and treatment met expected standards. However, doctors did not properly explain the complexities of Mrs M's condition to her daughter. They could have done more to prepare her for Mrs M's death, which would have given her an opportunity to say goodbye to her mother.

Putting it right

Following our report the Trust acknowledged the failings and apologised for them. It put together an action plan to show how it has learnt from the complaint. It paid Mrs L £300.

Organisation we investigated

Gloucestershire Hospitals NHS Foundation Trust

Region

South West

City or county

Gloucestershire

Summary 166/May 2014

Trust failings delayed funding application

A Trust's delays in putting forward a funding application influenced a patient's decision to seek private treatment.

What happened

In spring 2012 Mr T was diagnosed with an inguinal hernia (in his groin) and was told by his consultant gastrointestinal surgeon that he needed surgery. The next month the consultant wrote to Mr T's GP about making an exceptional funding application and after an exchange of letters, the consultant made a funding request. In summer 2012 Mr T booked himself in for a private procedure. Two days earlier the Primary Care Trust (PCT) had written to Mr T turning down his application because of insufficient evidence and offering him an appeal. However Mr T replied that he was in too much pain and he feared the appeal would take too long so he went ahead with the private operation.

What we found

The Trust contributed to the 14-week delay in Mr T having his funding application considered. In addition, we found that the consultant failed to provide enough information in the application to secure funding.

There were no failings in how the Clinical Commissioning Group (CCG, formerly the PCT), handled the case.

Putting it right

The Trust acknowledged the failings outlined in our report and apologised for them. It paid Mr T 75% of the NHS fee for the operation.

Organisations we investigated

Bristol Clinical Commissioning Group

University Hospitals Bristol NHS Foundation Trust

Region

South West

City or county

Bristol

Summary 167/May 2014

Dentist failed to document that treatment options and risks were explained

Mr F sought emergency dental treatment because of pain in a tooth that supported a bridge.

What happened

The dentist carried out root canal treatment, which resulted in the bridge debonding. Eventually the tooth went black.

What we found

Mr F's treatment was reasonable but there were no records to show that treatment options and associated risks had been properly explained to him, so Mr F had not given valid consent for the treatment to go ahead. However, we could not say that the outcome for Mr F would have been different if the treatment options had been fully explained.

Putting it right

The dentist wrote to Mr F to acknowledge failings, apologise and explain what action will be taken to learn from these events.

Organisation we investigated

A dental practice

Region

East

City or county

Cambridgeshire

Summary 168/May 2014

Trust forced patient to accept restrictions on his liberty

Mr B was admitted to the Trust as a voluntary patient but was forced to accept limits on the amount of time he could be in the gardens of the hospital. He stayed at the Trust because of threats that he would be detained if he tried to leave.

What happened

Mr B complained about the care and treatment provided by the Trust before and during his hospital admission. He said he was only detained on the basis of fabricated lies, and a hospital admission was unnecessary. Once admitted, he said that he only stayed because he was threatened with arrest if he tried to leave. Mr B also complained about the Trust's contact with DVLA.

What we found

The care and treatment given by the Trust were reasonable and Mr B's admission to hospital was appropriate. However, he was forced to accept restrictions on his liberty, such as not being allowed to use the garden freely, and he only stayed in hospital beyond a certain point because of threats he would be detained if he tried to leave. We found no cause for concern about the contact with DVLA.

Putting it right

The Trust wrote to Mr B to apologise for failings and explain what action it would take to make sure this does not happen again. It paid Mr B £750 in recognition of the distress and upset these events caused and continue to cause him.

Organisation we investigated

Lincolnshire Partnership NHS Foundation Trust

Region

East Midlands

City or county

Lincolnshire

Summary 169/May 2014

Delayed diagnosis of cleft palate in three-year-old girl with speech problems

The Trust failed to carry out relevant investigations and assessments and this led to a delayed diagnosis of a cleft palate for a little girl.

What happened

Mrs N's three-year-old daughter, R, was referred to the ear, nose and throat department at the Trust with problems related to the sound of her speech. After three outpatient appointments at the Trust over the course of five months, a speech and language therapist from a different NHS organisation referred R to a lead speech and language therapist in the regional cleft lip and palate service at a different trust. R was then diagnosed with a cleft palate, for which she has had to undergo surgery.

What we found

The Trust failed to arrange relevant investigations and assessments to identify the cause of R's persistent speech problems. We concluded that R's cleft palate could have been diagnosed and treated at an earlier stage. These delays would have led to R suffering some ongoing speech problems and would have affected her confidence.

In its response to her complaint, the Trust did not explain to Mrs N what it could have done differently. In addition, Mrs N experienced unnecessary and protracted delays in the complaints process. This caused her further, unnecessary stress.

Putting it right

The Trust acknowledged and apologised for its failings, and put together an action plan that demonstrated that it had learnt from its mistakes. It paid Mrs N £1,000 as a financial remedy for the distress she experienced.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Region

East

City or county

Essex

Summary 170/May 2014

Care home misled complainant about amount of physiotherapy given to her son and PCT failed to properly investigate complaint

J, Mrs K's son, had an acquired brain injury and was assessed for physiotherapy during his placement in a care home run by Voyage Care. J's mother became convinced that he was not receiving the amount of therapy he needed. Eventually the dispute resulted in a breakdown in trust and the termination of J's placement.

What happened

Mrs K complained to the Primary Care Trust (PCT) about her concerns. The PCT investigated the complaint and found some failings on the part of Voyage Care. However, the PCT did not agree with Mrs K about the number of missed physiotherapy sessions, did not attempt to consider the impact on J's health or consider whether Voyage Care should take some or all of the responsibility for the breakdown in communication that led to the ending of J's placement. The PCT also did not explain what action it had taken to address the failings it had identified. Mrs K brought her complaint to us and, when the NHS restructured, we referred it to the Clinical Commissioning Group (CCG) with an understanding that a new investigation would address shortcomings we had identified in the PCT's complaint handling.

The CCG conducted an internal audit of the complaint and concluded that J did not get the assessed amount of physiotherapy, but it was unable to gauge the extent of the shortfall. It also concluded that Voyage Care had overcharged the PCT for therapy sessions. The audit did not deal with responsibility for the breakdown in trust or consider the impact on J's health. The audit found the investigation had been delayed because of the good relationship between the PCT and Voyage Care. The investigation had lacked thoroughness and a clear conclusion. The CCG apologised to Mrs K and outlined service improvements, but refused a request for financial redress.

Voyage Care refunded £640 for under-provided therapy sessions.

What we found

Both local investigations failed to calculate the amount of under-provided physiotherapy sessions correctly.

Voyage Care contributed significantly to the breakdown in trust that ended J's placement.

We were critical of the thoroughness of the CCG's investigation and the measures it had taken to hold Voyage Care to account for its failings. We also criticised the CCG for failing to take account of the impact of the shortfall in therapy on J's health, and its failure to apportion responsibility for the breakdown in trust.

There were failings in the CCG's complaint handling that extended to dismissing Mrs K's concerns, and bias.

Finally, we criticised the CCG for not remedying the complaint and refusing financial redress.

As a result, we concluded that Mrs K was left not knowing how much difference these failures had made to J's health and wellbeing. She experienced loss of trust, distress, frustration and anger. The CCG's complaints process failed to take Mrs K seriously or reassure her that it protects the interests of vulnerable patients and their families.

Putting it right

Both bodies acknowledged and apologised for their failings and agreed to pay Mrs K compensation. The CCG said it would prepare an action plan to address failings in its complaint handling and agreed to take action to recover the full amount of the overpayment from Voyage Care.

Organisations we investigated

Sandwell and West Birmingham Clinical Commissioning Group

Voyage Care

Region

West Midlands

City or county

West Midlands

Summary 171/May 2014

Poor complaint handling by trust

Mr P complained to us about the way that the Trust handled the complaints he made after he wrote to them asking for information.

What happened

Mr P wrote to his Trust in autumn 2012 to ask for some information. The Trust treated his letter as a complaint. Mr P then complained in the spring of 2013 and when he did not get a reply, he sent another copy of his letter a month later.

He complained to us that he considered that NHS complaint handling regulations were not followed because the Trust's responses were neither speedy nor efficient. Mr P was also concerned that the Trust did not, as far as reasonably practicable, keep him informed about the progress of his complaints.

What we found

It was reasonable of the Trust to consider Mr P's letter of spring 2013 to be a continuation of an ongoing complaint. However, Mr P encountered poor complaint handling after the Trust received the letter.

The Trust did not update Mr P and did not issue a further response until later in 2013. It did not apologise for the delay and did not apologise for failing to update Mr P about his complaint.

Another complaint Mr P made later in 2013 encountered similar delays in updates and response.

We upheld the complaint.

Putting it right

The Trust drew up an action plan to prevent similar instances of poor complaint handling in the future.

Organisation we investigated

Lancashire Teaching Hospitals NHS Foundation Trust

Region

North West

City or county

Lancashire

Summary 172/May 2014

Doctors missed opportunity to provide better outcome for patient

Mrs M's daughter, Mrs A, complained that doctors did not act on signs of postoperative complications soon enough, and that the family were provided with false assurances about Mrs M's condition.

What happened

Mrs M had ulcerative colitis (an inflammatory bowel disease). She had been experiencing flare-ups of her condition (pain and diarrhoea). A sigmoidoscopy (where a doctor looks at the rectum and colon with a flexible tube) found she had severe ulcerative colitis, and she was admitted to hospital for treatment. She was treated with intravenous steroids. The Trust did not think she was improving and after discussions with her consultant and a consultant surgeon, Mrs M had surgery to remove her large intestine resulting in a stoma (opening between the inside of the body and the outside) through which faeces passed into a bag.

Mrs M was initially stable but over the next few days her abdominal drains produced large amounts of fluid and her pain increased. She was given antibiotics five days after the operation and then returned to theatre for a second operation. She continued to be unwell and was moved back to the high dependency unit. Mrs M continued to deteriorate and sadly died.

What we found

There were many things the Trust got right, including the sigmoidoscopy, the treatment Mrs M received before her operation, and the first operation. However, after the first and second operations, the Trust did not get a number of things right. There were no observations for four hours on one occasion, and doctors took little action to investigate the cause of Mrs M's infection. The consultant surgeon failed to hand over Mrs M's care to another consultant when he went on leave and junior staff were left to manage Mrs M's illness. They did not recognise the seriousness of her condition, and communication with the family was poor. There was poor documentation, and the high dependency unit team and the intensive care team did not put appropriate plans in place. Despite blood cultures that showed Mrs M had a widespread fungal infection, this was not diagnosed or treated. Trust staff missed an opportunity that might have allowed Mrs M to recover. However, she was very ill and on the balance of probabilities, it was likely that she would have died at that point.

Putting it right

The Trust apologised to Mrs A and paid her £1,000 for her distress. It drew up an action plan to address the failings that it had not already addressed.

Organisation we investigated

North Tees and Hartlepool NHS Foundation Trust

Region

North East

City or county

Hartlepool

Summary 173/May 2014

Care provided met accepted standards

The care and treatment provided to a dying woman was in line with accepted standards, although communication with her family could have been better.

What happened

Mrs L, who had terminal cancer and other related conditions, was admitted to hospital with bowel problems. Doctors assessed her and found that surgery would not be beneficial. Antibiotics were prescribed but after several hours she had not responded to this treatment. Doctors decided that she was dying and began a palliative care pathway.

Mr L, Mrs L's husband, complained that the Trust did not tell him how serious her condition was. However, after he arrived at the hospital he was fully informed of her condition and prognosis. Unfortunately, by this stage she was no longer able to communicate.

What we found

The Trust's assessment, care and treatment of Mrs L were in line with acceptable standards. The Trust could have told Mr L about the severity of her condition earlier, but there was no obligation to do so because Mrs L had capacity to make decisions about her treatment for most of the day. Therefore, there was no service failure.

Mr L also complained about the Trust's complaint handling. We found that its initial response was very poor. However, as its subsequent responses addressed Mr L's concerns, the overall service provided did not fall below an acceptable standard.

We did not uphold the complaint.

Organisation we investigated

East Sussex Healthcare NHS Trust

Region

South East

City or county

East Sussex

Summary 174/May 2014

No failings identified in clinical care, but failings in complaint handling

The Trust gave Mrs P reasonable information about an operation, but there were failures in its complaint handling.

What happened

Mrs P complained about the information and explanations given before and after a hysterectomy. The Trust initially explained that there were failings and a breakdown in communication. The Trust promised a further response and a personal apology from the member of staff involved. The further response from the Trust explained that there were no failings. The Trust maintained that Mrs P could still expect a personal apology.

What we found

Although Mrs P was undoubtedly confused about the procedure she received, we did not see that this was because of any failings in the information the Trust gave her.

There were failings in the Trust's complaint handling. Although it knew this would not happen, the Trust repeatedly promised Mrs P a personal apology from the clinician involved in her care.

Putting it right

Following our report, the Trust apologised to Mrs P for its failings in complaint handling. It paid her £250 for the distress its complaint handling caused, and explained what steps it would take to make sure that the failing does not happen again.

Organisation we investigated

Chesterfield Royal Hospital NHS Foundation Trust

Region

East Midlands

City or county

Derbyshire

Summary 175/May 2014

G4S handled complaint poorly

Mr J, who was detained in prison at the time, had been taking medication for a number of years. The prison GP stopped his medication without any warning, causing Mr J withdrawal symptoms.

What happened

Mr J had been prescribed strong painkillers for a number of years. He transferred to the prison in autumn 2011 and his medication was regularly reviewed and changed appropriately.

In early summer 2013, the prison GP stopped Mr J's medication. The records show that in the following days Mr J reported feeling unwell. He was seen by the prison GP later in the year, who re-prescribed the medication.

Mr J complained about his medication being stopped, but the responses to the complaint did not explain the prison GP's decision to stop the medication without warning. As Mr J was unhappy about the responses he had received, he asked us to investigate.

What we found

The decision to stop Mr J's medication abruptly was not reasonable or done in accordance with national guidance, given the potential for withdrawal symptoms, which Mr J suffered.

Complaint handling was unreasonable, and caused Mr J unnecessary frustration.

Putting it right

G4S Care and Justice Services acknowledged and apologised for the failings identified in our report and the effects they had on Mr J. They paid him £500 as compensation for the withdrawal symptoms, pain and anxiety he suffered when his medication was inappropriately stopped, and for the frustration caused by the poor complaint handling.

G4S Care and Justice Services prepared an action plan to demonstrate what it will do to make sure that it has learnt lessons from the poor complaint handling, and what it has done, or will do, including timescales, to review the process for stopping medication in line with national policy and procedure.

Organisation we investigated

G4S Care and Justice Services

Region

East

City or county

Hertfordshire

Summary 176/May 2014

Poor communication and incorrect information from GP practice and PCT was distressing

We upheld Ms T's complaint about Milton Keynes Primary Care Trust (PCT) because of poor communication. We also partly upheld her complaint about a GP practice.

What happened

Ms T's GP Practice changed its boundary area and wrote to say she would be removed from its list because of this. Ms T appealed. She said it would be very difficult for her to attend another local surgery and the Practice hadn't taken her age and disability into account, so she had been discriminated against. The Practice told her that the PCT had told it that it could not make exceptions, and that there was no discrimination because no exceptions had been made. Ms T approached the PCT, which told her that it was the Practice's decision but she should write to the PCT with more information in support of her appeal. Ms T did this but the PCT did not respond and the GP Practice removed her from its list.

What we found

The communication with Ms T was confusing and unhelpful. The GP Practice told her the PCT would not allow an exception to be made for her and the PCT told her it could not make the Practice make an exception for her. The Practice did not give a reasonable explanation of why it would not allow Ms T to stay on its list. It did not show that it had considered the *Equality Act 2010*, which says that service providers should consider the impact of their decisions on people with protected characteristics, including age and disability.

However, it extended the deadline for Ms T's removal from the list a number of times to allow her more time to find a new GP. We partly upheld the complaint about the Practice.

The PCT encouraged Ms T to appeal to it, even though it could not influence the decision. It then failed to reply to her letters, which left her feeling ignored and rejected. We fully upheld the complaint about the PCT.

Putting it right

Both organisations apologised, wrote to Ms T to explain how they would prevent similar issues from happening again and paid her £250 each in recognition of the distress she experienced as a result of the failings we identified.

Note: When the NHS restructured, NHS England's Hertfordshire and the South Midlands Area Team took over the responsibilities of what had been Milton Keynes PCT.

Organisations we investigated

A GP practice

NHS England – Hertfordshire and the South Midlands Area Team

Region

East

City or county

Hertfordshire

Summary 177/May 2014

Poor care given to patient with heart condition

Mr F had a hole in his heart and suffered from irregular heartbeats. He was referred to hospital, where he was seen by a doctor who failed to provide appropriate treatment before, sadly, Mr F died.

What happened

Mr F, who was 45 years old at the time, went to see his GP about his irregular heartbeats.

The GP referred Mr F to a GP with a special interest in heart problems. This GP noted that his heart was not working properly and that it had a hole in it, and he referred Mr F to hospital.

Some eight weeks later, Mr F was seen by a doctor at the Trust. Mr F saw the doctor two more times before, sadly, he died four months after his first appointment at the hospital because of his heart condition.

What we found

The GP heart expert acted appropriately.

There was sufficient urgency in the hospital's investigations and treatment. However, the doctor at the hospital failed to: check Mr F's potassium level; give him appropriate medication for his heart condition; tell Mr F and his partner how serious his heart condition was; and discuss the matter with a senior colleague.

If the hospital had treated Mr F appropriately, it would have reduced his chances of dying.

Putting it right

The hospital apologised for the poor care and treatment it gave Mr F. It paid Mr F's partner £3,000 compensation and took action to make sure that it and the doctor who treated Mr F had learnt from the matter.

Organisations we investigated

Central Manchester University Hospitals NHS Foundation Trust

Central Manchester Clinical Commissioning Group

Region

North West

City or county

Greater Manchester

Summary 178/May 2014

Cancer diagnosis delays shortened man's life by six months and caused unnecessary pain and distress

Mr A was too unwell to have chemotherapy that would have given him another six months of life. The Trust was not open and accountable when handling his wife's complaint.

What happened

Mr A had blood in his urine, and test results showed abnormal cells and stones in his bladder. Before further tests could be arranged, Mr A was admitted to hospital with large clots of blood in his urine. His symptoms settled, and he was sent home. Further tests showed other tests were needed, and a doctor asked for those tests to be done urgently. The hospital staff told Mr A's wife, Mrs A, that someone would call her the next day about a date for the tests, but that did not happen.

Nearly five weeks passed, during which time Mrs A contacted the hospital. She was told Mr A was on the waiting list. The next month Mr A was admitted to hospital with serious kidney failure. He was treated for this, and early the next year had the tests that the doctor had requested some two months earlier. These showed a large and aggressive tumour in his bladder. Doctors then discovered the cancer had spread to other parts of his body. Mr A was by then too unwell for the chemotherapy that might have extended his life. He was discharged, but returned to hospital and died there soon after.

What we found

The tests requested should have happened within a few days. If they had, it was unlikely Mr A's kidneys would have failed. The need to treat kidney failure before the tests could be done caused further delay. Overall, there was a 50-day delay in Mr A's diagnosis and treatment. Mr A suffered painful, unnecessary treatment for kidney failure as a result. Also, he lost the chance to have chemotherapy that would have extended his life by about six months. Mrs A suffered distress from watching her husband undergo painful treatment, and she was denied six months additional time with him. The Trust did not respond to Mrs A's complaint in an open and accountable way because it did not acknowledge the delays to Mr A's diagnosis.

Putting it right

The Trust acknowledged its failings and apologised for them. It paid Mrs A £3,000 compensation, and drew up an action plan that showed learning from its mistakes so they will not happen again.

Organisation we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Region

East

City or county

Essex

Summary 179/May 2014

Surgeon removed patient's organs unnecessarily

Mrs D had surgery to remove an ovary. The surgeon removed not only the ovary but her uterus, appendix and omentum without her consent or knowledge. After surgery her wound reopened, and the doctors at the hospital did not treat this properly.

What happened

Mrs D complained that her consent for surgery was not properly obtained, that the surgery was inadequate and she had other organs removed without her knowledge. She also said her postoperative care was inadequate. She wanted the Trust to recognise and apologise for its failings, pay her compensation, and make changes to procedures.

What we found

Mrs D's uterus, appendix and omentum were removed when there was no clinical need to do so. After the surgery, the doctors caring for her failed to carry out adequate assessments and treatment. The postoperative care and treatment provided for her fell below the required standards. Mrs D suffered pain and distress because of these failings and financial hardship because of the costs associated with having corrective treatment and psychotherapy.

Putting it right

The Trust acknowledged and apologised for its failings and paid Mrs D £11,050 compensation. It also produced an action plan to make sure that there was learning from the complaint.

Organisation we investigated

University Hospitals Bristol NHS Foundation Trust

Region

South West

City or county

Bristol

Summary 180/May 2014

Trust and CCG followed Department of Health guidance

When Miss T's PIP breast implants ruptured, she approached the Trust and the Clinical Commissioning Group (CCG) to request a single mixed NHS/privately-funded procedure to remove and replace them.

What happened

Miss T was given the impression that a single mixed procedure would take place right up until the day before she was due to meet her NHS surgeon. She was then told that such a procedure was not possible because she did not meet the relevant criteria.

What we found

We looked at information from Miss T, the Trust and the CCG. We also looked at national guidelines about PIP breast implants and local guidelines about breast prosthesis removal or replacement.

The Trust and CCG had followed the relevant guidelines in deciding not to perform a single mixed procedure. However, we identified failings because Miss T was erroneously told that this procedure could be performed. We therefore partly upheld the complaint.

We also found that the CCG could have given Miss T a better complaint response rather than limiting itself to comments made previously by the Trust.

Putting it right

The CCG acknowledged and apologised for its failings and reiterated the relevant Department of Health guidance to its staff so a similar situation does not arise again.

Organisations we investigated

Hillingdon Clinical Commissioning Group

Imperial College Healthcare NHS Trust

Region

London

City or county

Greater London

Summary 181/May 2014

Mother gave birth in her car after maternity service errors

Mrs L attended her Trust because her waters had broken. The Trust advised her to return home, which she did. Later that evening, Mrs L gave birth on the way to hospital.

What happened

Mrs L went to the Trust's birth centre late in the evening because her waters had broken. A midwife examined Mrs L and did not think that she was in established labour. She advised Mrs L to go home. However, she did not speak to Mrs L about how she was feeling or observe how she was coping with contractions. The midwife also did not take into account the fact that, because Mrs L's waters had been broken for a long time, she was going to need to attend hospital for antibiotics at 2am (two hours later) even if she had not given birth by then. Mrs L left the birth centre and went home.

Later that night, Mrs L telephoned the Trust because she felt that her contractions were stronger. However, she was again advised not to go in. At around 2am Mrs L and her husband set off for the hospital for Mrs L to have antibiotics. However, Mrs L's labour progressed and she gave birth in the car on the way to the hospital.

What we found

The birth centre did not properly assess whether Mrs L was in labour before it concluded that she was not and sent her home. The Trust's communication with Mrs L was not of an adequate standard because it did not take her views and reluctance to go home into account, and it gave her incorrect advice.

The Trust did not take Mrs L's individual circumstances into account. Mrs L would need antibiotics from the hospital if she did not give birth within two hours of arrival at the birth centre. Given the distance between Mrs L's home, the birth centre and the hospital, this essentially meant that Mrs L was going to spend much of the next two hours travelling. Mrs L should either have been admitted to the birth centre, or advised to go directly to hospital from the centre.

The cumulative effect of the failures in care led to Mrs L giving birth in her car, as there were repeated missed opportunities for appropriate care that could have prevented her traumatic experience.

Putting it right

The Trust acknowledged its mistakes and apologised. It paid Mrs L compensation of £1,000 in recognition of the distress she experienced and drew up an action plan that showed what service improvements it would put in place to prevent a similar situation from happening again.

Organisation we investigated

Buckinghamshire Healthcare NHS Trust

Region

South East

City or county

Buckinghamshire

Summary 182/May 2014

Poor communication led to delay in diagnosing sepsis

Mrs A complained about her father's care and a delay in diagnosing sepsis because of a lack of investigation and poor communication.

What happened

After a referral from his GP, Mr D attended a haematology clinic. Staff took blood for testing, but Mr D left the clinic before the blood results arrived. Staff found abnormalities in the test results that needed further investigation.

A consultant attempted to contact Mr D to advise him to go straight to A&E for intravenous antibiotics and vitamin K, and to stop taking his warfarin medication straight away. However, it was approximately three to four hours before anyone could contact Mr D so that he could go to A&E.

When he arrived at A&E, staff were not aware of Mr D's condition and there was a delay in getting him the antibiotics he needed and treating him for sepsis. He was transferred to a ward and then the intensive care unit. Mr D sadly died the next day.

What we found

There was a delay in Mr D's diagnosis of sepsis, and there were failings in the way that the Trust responded to Mr D's family's complaints.

We are not reassured that the Trust has learnt from what happened, or has put processes in place to make sure that the failings will not happen again. This is potentially significant because, although we could not say that in Mr D's case the delay caused his subsequent death, this may not be the case in the future for other patients.

We have noted the work that the Trust has done in response to what happened to Mr D, and we do not doubt that it has already made improvements. However, there are outstanding issues that have not yet been addressed, so we partly upheld Mrs A's complaint.

Putting it right

The Trust wrote to Mrs A acknowledging that it did not address all of her complaints and apologising for this. It gave Mrs A details of the improvements it has made following her complaints and how it is monitoring these. It also completed an action plan to address all of the failings found in the report. It shared this with us, Mrs A, the Care Quality Commission and Monitor.

Although we also recommended a financial payment of £1,000 for the distress caused by having to pursue the complaint, the family have said that they will not accept this payment.

Organisation we investigated

Stockport NHS Foundation Trust

Region

North West

City or county

Greater Manchester

Summary 183/May 2014

No failings in a diagnosis of conjunctivitis

Mrs L complained that an out-of-hours doctor failed to examine her eye and unreasonably misdiagnosed the cause of her symptoms.

What happened

Mrs L attended an emergency and urgent care centre in the summer of 2013 because of a red, swollen and painful eye. A doctor diagnosed conjunctivitis and prescribed her an antibiotic cream.

Mrs L's eye remained very painful and she visited her optician 19 days later. The optician made an urgent referral to Moorfields Eye Hospital and Mrs L attended its A&E department the same day. The eye hospital diagnosed Mrs L with an exposed calcific band keratopathy (a growth on the eye) and this was scraped and removed. Mrs L returned to A&E a week later and it was noted that the problem on her eye had healed and she was comfortable.

What we found

We found that the out-of-hours doctor recorded a reasonable history when he saw Mrs L. There was also evidence that he examined Mrs L's eye, although she disputes this took place. Overall, we found that the doctor made a reasonable diagnosis based on Mrs L's presenting symptoms and so we did not uphold the complaint.

Organisation we investigated

Partnership of East London Co-operatives

Region

London

City or county

Greater London

Summary 184/May 2014

GP Practice ignored wife's complaint about husband's care and treatment

A GP practice demonstrated poor complaint handling when it failed to respond to a second letter of complaint from a patient's wife about her husband's care and treatment.

What happened

Mrs J complained that the GP failed to provide an adequate examination of her husband's leg, only looking at it '*over the desk*'. She added that as a result, his leg became infected, requiring several trips to A&E.

Mrs J also complained about the GP's complaint handling. She said that while she sent her original letter of complaint to the PCT in autumn 2012, the Practice didn't respond until early 2013, when it explained that the complaint had only been forwarded to it 11 days earlier.

Mrs J did not receive this letter from the Practice and it was re-sent by recorded delivery. It is not clear when this finally arrived, but in a second letter to the Practice, sent in summer 2013, Mrs J referred to receiving its recent response, the contents of which she found to be unsatisfactory. The Practice did not reply to this letter.

What we found

Mr J saw a podiatrist who thoroughly examined his leg and identified an infection. During a later visit to the GP for a flu vaccination, Mr J told him about the infection and was prescribed medication. The GP asked Mr J to return to him if there was no improvement. We have found that this treatment, provided by the GP, was appropriate.

Although Mrs J had to wait too long for a response to her first complaint, this was not the Practice's fault.

The Practice told us that it could not provide a response to Mrs J's second letter of complaint without Mr J's consent. While correct, the Practice should also have applied this to Mrs J's initial complaint. The Practice should still have acknowledged Mrs J's second letter, explaining why it was unable to provide a response. The fact that it did not was a failing. We partly upheld the complaint.

Putting it right

The GP wrote to Mrs J apologising for failing to respond to her letter.

Organisation we investigated

A GP practice

Region

East

City or county

Essex

Summary 185/May 2014

GP failed to make home visits to older patient

A GP prescribed medication over the telephone, but only visited Mrs S once.

What happened

Mrs S was discharged after a short hospital admission. Her symptoms of agitation, hallucination and unreasonable, out of character behaviour worsened and her family requested a GP home visit. For the following 15 days, her family had several telephone consultations with the GP, and he prescribed sleeping medication and antibiotics. But he did not make any more home visits to review and assess Mrs S and evaluate his treatment plan. Mrs S was eventually readmitted to hospital, where she later sadly died.

What we found

The GP conducted an appropriate home visit but it was not reasonable that he did not return for more face-to-face assessments. It was also not reasonable that the GP changed Mrs S's prescriptions and prescribed different medication over the telephone without having seen her. We did not conclude that any failing led to her later death but we felt if the GP had visited, Mrs S's medication management may have altered the course of her later hospital admission.

Putting it right

The GP involved in this complaint was a locum, employed by an agency commissioned by the Area Team. The Area Team sent Mrs S's son a letter of acknowledgement and apology for the failings and shared the information in our report with the locum's agency. It liaised with the agency to put into place action to prevent something similar happening again and to show learning.

Organisation we investigated

NHS England - Essex Area Team

Region

East

City or county

Essex

Summary 186/May 2014

Practice removed patient from list without warning

Mr U complained that his GP Practice did not give him appropriate care and treatment for heel pain. Mr U also complained that he was unfairly removed from the Practice list after he complained about the care and treatment he received.

What happened

Mr U had a number of appointments at the Practice between summer and winter 2013 about his heel pain. He also complained to the Practice in late summer 2012 about the attitude of a GP. This complaint went unanswered.

The Practice recommended a number of treatment options for Mr U and made a referral to podiatry services for some specialist input. Unfortunately, the treatments recommended did not help Mr U's heel pain. Mr U kept the Practice updated on his work situation at this time and asked the Practice to provide letters for his employer explaining how the heel pain affected his work.

Mr U became more frustrated by his work situation and asked the Practice to do more to support him in his dispute with his employer. In winter 2013 the Practice removed Mr U from the Practice list after a discussion he had with one of the GPs during which the GP felt that Mr U was verbally aggressive towards her. The Practice cited relationship breakdown as the reason for removing Mr U from its list.

What we found

The Practice acted appropriately in the care and treatment it gave. Our adviser said that Mr U's condition was hard to treat and that different patients needed different treatments because there was no standard approach.

Although the Practice was unsuccessful in resolving Mr U's heel pain by the time he was removed from the list, this was not through any failing by the Practice.

We considered the notes of Mr U's consultations and phone calls with the Practice and agreed that there was a breakdown in the doctor patient relationship, and it was reasonable for the Practice to remove Mr U from its list because of this. We saw no evidence that the Practice had removed Mr U from the list because he had made a complaint. However, we decided that the Practice should have spoken to Mr U about the relationship breakdown and given him a warning before it removed him from its list. In failing to give Mr U a warning, the Practice denied him the opportunity to attempt to resolve the situation and discuss the issues that were causing the breakdown.

Putting it right

The Practice has apologised to Mr U for failing to give him an appropriate warning before it removed him from its list. It has also reviewed its guidance about GP removals and has confirmed that it will issue appropriate warnings before it removes a patient from its patient list in future.

Organisation we investigated

A GP practice

Region

South East

City or county

Oxfordshire

Summary 187/May 2014

Hospital failed to diagnose fractured hip, and operation was not to recognised standards

A patient did not receive the right scans to confirm whether she had fractured her hip. A later hip replacement did not use a recognised implant.

What happened

Miss B lived independently despite having dementia. She was taken to hospital after a fall at home. Four days later, staff carried out an X-ray because Miss B had complained of pain in her hip. The X-ray did not show a fracture and after two weeks Miss B was transferred to a rehabilitation unit. One week later, Miss B had more scans of her hip, and staff diagnosed a fracture. The hospital carried out a hip replacement operation, but the wound did not heal well and Miss B began to deteriorate mentally and physically. Miss B was discharged to a nursing home where she stayed for the rest of her life.

Miss B's niece, Mrs L, complained to us that the hospital should have diagnosed the fracture sooner. Mrs L felt that Miss B would not have gone into a nursing home if she had been diagnosed and treated earlier.

What we found

We partly upheld this complaint.

The hospital wrongly dismissed the possibility of a fracture after one X-ray. In order to fully consider the possibility of a fracture, the hospital should have examined Miss B's hip and carried out a side view X-ray and further scans. This did not happen. Miss B's pain early in the admission suggested that the hospital missed opportunities to diagnose the fracture sooner. This meant that Miss B was in pain for much longer than was necessary.

With regard to the hip replacement operation, the hospital used an implant that is not recognised in current best practice guidance. However, we did not find that this affected Miss B's subsequent recovery and her admission to a nursing home.

Putting it right

The hospital apologised to Mrs L, paid £1,500 to Miss B's estate, and completed an action plan that showed learning from the mistakes so that they will not happen again.

Organisation we investigated

Chesterfield Royal Hospital NHS Foundation Trust

Region

East Midlands

City or county

Derbyshire

Summary 188/May 2014

Insufficient staffing levels caused distress

A widow complained about several aspects of the care her late husband received when he was admitted to hospital with a head injury.

What happened

Mr M was admitted to hospital after he tripped and banged his head. Staff diagnosed him with a subdural haematoma (blood between the skull and the surface of the brain) but he was too unwell for surgery. Mr M was admitted to a complex needs ward where there were a number of confused patients wandering and causing disturbances. During his admission, Mr M had two falls. A CT scan then showed that the subdural haematoma had grown. Mr M sadly deteriorated and died in hospital.

Mrs M complained that her husband should never have been admitted to a ward with so many confused patients because he needed a restful environment to recover. Mrs M said that the chaotic atmosphere was distressing for Mr M and the whole family. Mrs M also said that Mr M's falls were preventable and directly led to his deterioration and death. Mrs M also complained that staff left Mr M sitting out of bed for too long, and did not give him intravenous fluids when she asked for them. Mrs M believed that her husband would have recovered from the subdural haematoma if he had received better care and treatment.

What we found

We partly upheld this complaint.

It was reasonable for Mr M to be admitted to a complex needs ward. However, there were not enough staff at the time to meet the needs of all the patients and this was a failing. Although nursing staff raised this issue, the Trust did not take any action. This created a chaotic atmosphere, which was distressing for Mr and Mrs M.

Mr M's falls were probably not avoidable, but there was a lack of one-to-one supervision between the first and second falls, and this was a failing. Mr M was left out of bed for too long. We could not link either of these failings to Mr M's deterioration and death.

It was reasonable not to give intravenous fluids when Mrs M requested them because Mr M was not dehydrated and could drink normally.

Putting it right

The Trust produced an action plan that showed what it had learnt from this complaint to prevent the failings happening again.

Organisation we investigated

United Lincolnshire Hospitals NHS Trust

Region

East Midlands

City or county

Lincolnshire

Summary 189/May 2014

Trust refused to readmit older woman with gangrene

Mrs Y was 72 and had previously suffered a stroke. She was under the care of her GP Practice and a specialist podiatry service for an ulcer on her foot.

What happened

The ulcer worsened over a period of four months and caused Mrs Y intense pain. Her GP suspected peripheral vascular disease (a build-up of fatty deposits in the arteries that restricts the blood supply to leg muscles). He arranged tests.

On the second of two home visits, another GP diagnosed gangrene and Mrs Y was admitted to hospital. Investigations revealed that a large artery in her thigh was blocked. Staff considered different options, including an operation to try to restore blood flow to Mrs Y's leg, an amputation or allowing the condition to stabilise while managing the pain. In discussion with doctors, Mrs Y's family chose the latter and she was discharged to a nursing home after three and a half weeks in hospital.

Mrs Y's gangrene then worsened and spread to her ankle. Two weeks after her discharge, a GP called the hospital to make an urgent referral and to arrange for her to be readmitted. The hospital told the GP that Mrs Y was not fit for surgery and the hospital could not do anything for her. A hospice nurse was assigned to arrange an end-of-life care plan.

Mrs Y's condition continued to decline rapidly and her family were told that she would die. After a further two weeks, at the prompting of nursing home staff, a GP arranged for her to be taken by ambulance to the Trust. She was admitted through the emergency department and her leg was later amputated. The hospital discharged her to the nursing home.

What we found

We investigated complaints about the GP Practice and the hospital Trust. The care provided by the Practice had been reasonable, although its record keeping and complaint handling needed improvement.

Mrs Y's care at the Trust was reasonable during her first admission. However, she was wrongly refused readmission by a junior doctor, who made an error of clinical judgment. As a result, her condition deteriorated very significantly and she was placed at high risk of death.

Putting it right

The Trust reviewed our recommendations and provided a formal response, including an apology and actions to avoid similar problems in future, and the Practice apologised and reviewed its record keeping to make sure that it complies with General Medical Council guidance. The Trust also paid Mrs Y £2,000 in recognition of the distress, pain and unnecessary risk caused.

Organisations we investigated

A GP practice

East Kent Hospitals University NHS Foundation Trust

Region

South East

City or county

Kent

Summary 190/May 2014

GP failed to refer husband for further investigations for prostate cancer and delayed in diagnosing wife's heart problems

Mr B visited his GP in autumn 2007 with symptoms that could be suggestive of prostate cancer. Mrs B visited the same GP early the next year complaining of breathlessness.

What happened

The GP received Mr B's test results soon after the first consultation. These indicated that Mr B was at increased risk of prostate cancer. According to guidelines issued by the National Institute for Health and Care Excellence (NICE), he should then have referred Mr B to a specialist but the GP did not refer him at that stage. Mr B returned to his GP in early summer 2008, when further tests were carried out. The GP referred him to a specialist and he was diagnosed with an aggressive form of prostate cancer, for which he underwent radiotherapy.

Mrs B visited her GP in early 2008 complaining of breathlessness. He prescribed an inhaler. Mrs B returned to her GP in the spring of the following year and her GP referred her for an ECG (a test that records the electrical activity of the heart). Shortly afterwards she was diagnosed with heart failure (the heart not pumping the blood around the body as well as it used to) and atrial fibrillation (a condition that causes an irregular and often abnormally fast heart rhythm).

What we found

We decided to investigate in spite of the significant time that had passed. The delay in diagnosis resulting from the GP's failure to refer Mr B immediately had led to an increased risk of Mr B's cancer recurring or spreading to other parts of the body.

The GP did not record details of his examination of Mrs B's chest or heart in spring 2008; he did not record her heart rate or his assessment or diagnosis of her condition. In early 2009, the GP referred Mrs B for an ECG but did not record his finding of an irregular pulse, Mrs B's heart rate or any assessment for heart failure. We could not say whether appropriate examinations took place because there were no proper records. We concluded that there was no evidence of an adequate history or examination when Mrs B presented with breathlessness in spring 2008. There was no record of her heart rate or any assessment for heart failure when she returned to the GP the following year, although there was a full history in the referral letter that indicated the GP had been recording Mrs B's pulse.

The GP said that he examined and assessed Mrs B correctly, but we were unable to come to a view on this in the absence of appropriate records. We found that the delay in diagnosis gave Mrs B an increased stroke risk. We also found that Mrs B's symptoms of breathlessness could have been alleviated if the GP had prescribed the correct medication earlier. We did not think that the delay in diagnosing her condition had had a long-term impact on Mrs B's prognosis, however.

Putting it right

We recommended that the GP should discuss the outcome of the investigation at his next appraisal. The GP paid Mr B £500 in recognition of the distress caused as a result of the failure to refer him in good time.

Organisation we investigated

A GP practice

Region

South East

City or county

Surrey

Summary 191/May 2014

Complaint about delay in diagnosing epilepsy and failure to provide relevant advice and information

Mr J complained about his treatment by the Trust after he went to A&E after a seizure.

What happened

Mr J had a seizure and went to A&E. Staff discharged him with a referral to neurology but did not give him the appropriate safety advice about driving. When Mr J visited the neurology clinic, he was appropriately assessed and referred for cardiac investigations. Clinic staff deferred the diagnosis of epilepsy and relevant medication while they waited for the results of the investigations. Mr J did not get copies of the clinic letters from his neurology appointments and was left confused about his diagnosis. Although staff correctly advised Mr J not to drive, he complained that they did not give him information about possible benefits available to him to help with his travel costs. Staff discussed a referral to the epilepsy nurse, but the hospital did not offer Mr J an appointment.

What we found

A&E staff did not give the appropriate safety advice but there was no delay in reaching an epilepsy diagnosis because it was reasonable for them to request further investigations. We found that Mr J was not offered an appointment with the epilepsy nurse or copies of the clinic letters from his neurology appointments. This left him confused about his diagnosis and distressed by the possible impact of this on his work life and ability to drive. We found that the information about benefits was available to him via relevant leaflets and that the individual doctor involved could not be expected to provide advice about benefits.

Putting it right

Following our investigation, the Trust agreed to review its policies and procedures regarding referrals to the epilepsy nurse. It also agreed to make sure that A&E staff offer appropriate safety advice and that all patients are given copies of clinic letters from neurology appointments.

Organisation we investigated

University Hospitals of Leicester NHS Trust

Region

East Midlands

City or county

Leicester

Summary 192/May 2014

Inconvenience and frustration when dental practice refused to give treatment and then handled complaint poorly

Miss H complained that the Dental Practice refused to give her another appointment after she had cancelled some appointments with her dentist. She also felt that it handled her complaint poorly.

What happened

Because of her work commitments, Miss H had to reschedule several dental appointments, each time giving the Practice ample notice. She said that staff told her this would not be a problem. The Practice then told her that it would no longer offer her any appointments to continue the treatment that it had started. Miss H then had to get her treatment done elsewhere, and pay again for an initial consultation.

Miss H and the Practice exchanged emails in an attempt to resolve the complaint, but the Practice refused to refund the money she had paid or offer her another appointment.

What we found

In the circumstances, the Practice was wrong to refuse to continue treating Miss H. It also dealt with her complaint poorly, responding in an adversarial manner.

Miss H was frustrated and inconvenienced when the Practice decided not to give her an appointment to continue the treatment that had been started, and was left out of pocket. Her frustration was compounded by the Practice's failure to be customer-focused when responding to her complaint.

Putting it right

The Practice acknowledged the failings we identified and apologised for the injustice that resulted.

It paid Miss H £100 as compensation.

Organisation we investigated

A dental practice

Region

South East

City or county

Kent

Summary 193/May 2014

Trust gave patient good care, but communication with her family was poor

Mrs A's son, Mr A, was concerned about the care and treatment of his mother during her two-day admission to the Trust. He thought her care and treatment were inadequate and may have led to her premature death.

What happened

Mrs A arrived at the hospital's A&E in an ambulance. The Trust admitted her with abdominal pain and shortness of breath. Staff noted that she was confused. She had fallen at home the previous day but had not wanted to go to hospital.

The hospital kept Mrs A under review but her health declined very quickly on the second day of her admission and she died.

When her family raised concerns about the unexpectedness of her death and questioned the Trust about Mrs A's care, the Trust investigated the complaint and responded with an explanation of the treatment provided. It concluded that she had received appropriate care. However, it acknowledged that staff failed to communicate just how unwell Mrs A was and that staff did not discuss the plan for a do not attempt resuscitation order (DNAR) with her family.

What we found

There were no failings in the hospital's care and treatment of Mrs A. Medical and nursing staff recognised that she was seriously unwell. Sadly, despite treatment, she deteriorated and died relatively suddenly. We found that her medical management had been appropriate and that her death was not preventable.

We agreed with the Trust that there had been failings because staff did not discuss Mrs A's poor condition or the plan for the DNAR order with her family. While the Trust acknowledged the failings and had apologised, we saw no evidence that the Trust planned to take action to prevent this occurring again.

Putting it right

We recommended that the Trust take action to improve its communication with families.

Organisation we investigated

Royal Berkshire NHS Foundation Trust

Region

South East

City or county

Reading

Summary 194/May 2014

Poor communication with patient's family

The Trust did not communicate well with Mr Ys family and did not explain the reasons why a do not attempt resuscitation (DNAR) order was in place.

What happened

The Trust admitted Mr Y to hospital with a terminal illness. Staff treated his acute illness and discharged him with a care package to be looked after at home. He sadly died six days later.

His daughter complained that the Trust had not explained why her father was subject to a DNAR order, wrongly discharged him and should have told the family that he was at the end of his life.

What we found

We found that the Trust's discharge arrangements were good and that it could not have known Mr Y would die so soon after discharge. We did not uphold this part of the complaint.

We found that the Trust's communication was not good and in particular, it had not properly explained the DNAR order.

Putting it right

The Trust accepted our findings and drew up an action plan that showed how it would prevent a similar thing happening in future, and how it would audit the use of DNARs and work with the Care Quality Commission to make improvements.

Organisation we investigated

Plymouth Hospitals NHS Trust

Region

South West

City or county

Plymouth

Summary 195/May 2014

Trust failed to adequately assess and treat older patient

Mr A was admitted to hospital following a fall. Staff failed to adequately assess him and delayed giving him appropriate antibiotics.

What happened

Mr A fell and cut his head and was admitted to the Trust. Staff found a urine infection and suggested this was the reason he had fallen. The Trust moved Mr A to a different hospital at the same Trust the next day. Staff at the new hospital told his granddaughter, Ms A, that he also had a chest infection. During his admission, Mr A had several falls and sadly died as an inpatient.

Ms A complained about hydration, how staff managed his confusion, his falls, hospital acquired pneumonia, a delay in staff swabbing a wound Mr A sustained during a fall, and the standard of general nursing care. She also complained that staff attitude, communication and record keeping were poor.

What we found

There was a delay in staff starting antibiotics twice, problems with fluid charts, a lack of detailed assessment of Mr A's cognitive function and identification of delirium on admission, failure to adhere to infection control policy in relation to soiled clothing, failure to appropriately risk assess and manage falls, and failure to adequately communicate with Mr A's family.

However, we did not conclude that these failings caused Mr A pain or distress, or that they contributed to his death.

Putting it right

The Trust apologised to Ms A for the failings identified and prepared an action plan that outlined how it will improve its service for future patients.

Organisation we investigated

Sussex Community NHS Trust

Region

South East

City or county

Brighton and Hove

Summary 196/May 2014

Trust failed to admit patient to stroke unit after he arrived at A&E

Mrs R complained about her husband's care and treatment when he went to A&E in the winter of 2012. Mrs R complained that there was an avoidable delay in staff diagnosing that her husband had had a stroke that led to delay in giving him necessary treatment.

What happened

Mr R attended A&E in late 2012 after an episode of a sudden and severe headache with limb numbness, slurred speech, confusion and dizziness. This began in the early hours of the morning and lasted all day. Mr R's symptoms got worse during the day.

After Mr R saw his GP, his wife called an ambulance. Mr R arrived in A&E at around 6pm. Staff carried out a scan, and told Mr R it was normal. They sent him home, after telling him to go to a clinic the next day.

Mr R went to the clinic the next day. A stroke specialist reviewed the previous day's scan and decided that Mr R had had a stroke. The Trust admitted Mr R and he stayed in hospital until mid-winter 2012.

What we found

We took clinical advice from a stroke specialist and found that the Trust should have admitted Mr R to the acute stroke unit when he presented at A&E. Staff should not have sent him home.

However, while it was a concern that this happened, we were reassured by clinical advice that the delay had not had an adverse impact on the outcome for Mr R. Based on the evidence we saw, we were persuaded that, unfortunately, Mr R would have been left with the same difficulties even if he had been admitted straight away.

Putting it right

The Trust wrote to Mr and Mrs R to acknowledge the failure to admit Mr R to the acute stroke unit and apologise for this.

It produced an action plan to address the failings we identified.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Region

West Midlands

City or county

West Midlands

Summary 197/ June 2014

GP failed to refer woman to dermatologist after changes to moles

When Ms B noted changes to moles on her face, her GP did not make a note of that part of the consultation, and did not refer her back to her dermatologist. Ms B later had surgery for the moles.

What happened

Ms B had a consultation with the GP at the Practice. They disagreed about whether Ms B had asked for a referral back to her consultant dermatologist over some changes to moles on her face. Ms B then saw a private dermatologist, who recommended that the Practice refer her to an NHS dermatologist. The NHS dermatologist went on to remove a precancerous mark from Ms B's face.

What we found

Ms B discussed the matter with her GP. He should have recorded the discussion and referred her to a dermatologist. Ms B's concern was that she might have skin cancer, given her previous history. Ms B is clear that she does not think the GP's actions ultimately made her medical situation any worse, as she eventually had the treatment she needed. However, his failure to refer her caused her frustration and considerable time and inconvenience in having to seek an alternative consultation. This injustice was compounded by the GP's failure to acknowledge the conversation took place, or record any details of it.

Putting it right

The Practice apologised to Ms B and paid her £250. It also put a plan in place to learn lessons from its failings and make sure they did not happen again.

Organisation we investigated

A GP practice

Region

South East

City or county

Southampton

Summary 198/June 2014

Deaf patient denied access to BSL interpreter at GP practice

A Deaf patient did not have access to a British Sign Language (BSL) interpreter for GP appointments for three years because of a dispute over funding.

What happened

Mrs E is from Northern Europe. She is profoundly Deaf and uses BSL when communicating with organisations in the UK. She has very limited literacy skills in both her native language and English, and does not use speech or lip-read.

Mrs E registered with the Practice in 2007. Until summer 2011, the PCT funded a BSL interpreter for appointments at the Practice. However, in mid-2011 the PCT withdrew this funding and in response, the Practice decided it would not provide interpreters. It offered Mrs E longer appointment times and said staff would communicate with her through written notes.

Mrs E complained about this decision, with support from an advocate. She explained that she could not understand written English because this was not her primary language. She said she left appointments without knowing what was wrong or how to take her medication. Mrs E said she was worried about her health and that of her unborn child, and that the situation was causing her great distress. In response, the Practice said that it was the PCT's responsibility to fund interpreters, and that if Mrs E wanted an interpreter, it was her responsibility to arrange this. It repeated that it would communicate with her in writing. The Practice noted that Mrs E had been registered with it since 2007 and said that it '*would have hoped that her written language skills would have improved considerably since*'. It added that '*lack of proficiency in English does not constitute a disability in the Disability Discrimination Act*'.

The PCT told Mrs E that it did not agree with the Practice's position. It said that it was the Practice's duty, under the *Equality Act 2010* to provide reasonable adjustments to make sure its services are available to disabled people. It arranged the transfer of Mrs E's antenatal care to a local hospital where BSL interpreters were available, and in summer 2012 offered to help her move to a GP practice that provided online BSL interpreting services. Mrs E did not want to move practice, and the PCT took no further action to address the Practice's failure to provide communication support for Mrs E.

The Practice failed to take into account its responsibilities under the *Equality Act 2010* as a service provider. The Practice is required to take reasonable steps to make sure that, as a disabled person, Mrs E is not put at a substantial disadvantage in comparison with people who are not disabled. The Practice tried to make some adjustments for Mrs E, such as giving her longer appointments. However, because it did not take necessary steps to understand the way in which she communicated, its attempts were, on the whole, inappropriate and ineffective. The Practice wrongly concluded that Mrs E should be able to communicate through written English. She cannot, because she is a Deaf BSL user. In failing to recognise both of these important facts, the Practice has reached incorrect conclusions about its duties under the *Equality Act 2010*, which has led to its failure properly to consider whether the provision of a sign language interpreter is a reasonable adjustment under the Act.

What we found

The PCT knew about the effect of the Practice's decision on Mrs E, but did not use its powers as the Practice's commissioner to put the situation right. In failing to do so, the PCT did not demonstrate that it recognised the significance for Mrs E of the Practice's refusal to provide BSL interpreters.

Putting it right

Following our report, the Practice and the NHS England Local Area Team (which took over the PCT's responsibilities when the NHS restructured) acknowledged and apologised for their failings and paid Mrs E £3,000. They put together an action plan to show how they will meet Mrs E's needs in future, and they undertook to do the same for other patients with disabilities.

Organisations we investigated

A GP practice

NHS England - North Yorkshire and Humber Local Area Team

Region

Yorkshire and the Humber

City or county

York

Summary 199/June 2014

No evidence GP delay made condition worse

Mrs D visited her doctor with concerns about her circulation.

What happened

Mrs D complained that her GP delayed diagnosing a serious medical condition and making the appropriate referral to a specialist. She felt this has led to her condition being worse than it would have been if there was no delay.

What we found

There was a failure to carry out a proper assessment of Mrs D's symptoms and medical history, and her GP should have made a referral sooner. However, there was no evidence that these failings led to Mrs D's condition being worse, and so we did not uphold this aspect of the complaint. Having said this, we did not think that the Practice's response to the complaint had fully recognised or addressed its failings. We asked it to address this.

Putting it right

The Practice explained how the learning from the complaint had been taken forward, and how it would make sure that full assessments of presenting symptoms were carried out, and past history taken into consideration.

Organisation we investigated

A GP practice

Region

South West

City or county

Swindon

Summary 200/June 2014

Improvements in the provision of mouth care needed

Mrs K's husband was admitted to hospital with a suspected stroke.

What happened

Mrs K complained about the care and treatment provided to her husband. She had concerns about both the nursing care and his medical treatment.

What we found

Both the medical and nursing care had been appropriate. However, we felt that there was not enough evidence to show that the mouth care provided was sufficient.

Putting it right

The Trust apologised for the failing in mouth care. It also confirmed the actions it will take to make sure that patients receive appropriate mouth care.

Organisation we investigated

Norfolk and Norwich University Hospitals NHS Foundation Trust

Region

East

City or county

Norfolk

Summary 201/June 2014

Inpatient care on a ward

Ms E's mother was admitted to the ward in the final stages of illness to build up fluids and weight.

What happened

Ms E witnessed a number of basic errors and found staff to be unhelpful and rude. Ms E was not reassured that staff fully understood the medical situation, or gave the best possible medical care. Ms E was particularly concerned about the lack of doctor cover after 5pm.

What we found

The Trust had properly recognised failings in care and made real changes to address them. But it did not do enough to reassure Ms E that was the case.

Putting it right

The Trust told Ms E about the changes it had made as a result of her complaint.

Organisation we investigated

South Essex Partnership University NHS Foundation Trust

Region

East

City or county

Essex

Summary 202/June 2014

Patient unable to access support from maternity unit when she arrived in established labour

The Trust told Mrs K that she was not in established labour. It turned her away and gave her the impression she could not return for several hours. She gave birth at home with no medical help.

What happened

Mrs K went to the maternity unit as she was having regular contractions. After staff monitored her, they told her that she was not in established labour and to go home. Mrs K says that she was told that if she was in labour she '*would be shouting like the other women on the unit*'. She says that she was told to go home and not to return within the next four hours as she would be '*wasting their time*'. Mrs K was in severe pain at this time and could barely walk. However, because of the instruction not to return to the maternity unit for four hours, she went home. Soon after arriving home Mrs K gave birth in her bathroom without any medical support.

Mrs K said that she was left traumatised by the experience and could not bond with her baby for some time afterwards. She complained to the Trust about the lack of care she received from the staff at the maternity unit. She wanted improvements to be made at the Trust to make sure this does not happen again. She also asked for a financial remedy for the distress caused her.

The Trust said that Mrs K's assessment was appropriate but acknowledged some failings in communication. It declined to consider any financial remedy.

What we found

A student midwife carried out the examinations and some were not checked by a trained midwife. It was therefore difficult to establish if the clinical examination had been appropriate. The records did not reflect Mrs K's version of events or the clinical findings. On the balance of probabilities, we concluded that Mrs K was in established labour and should have been admitted to the maternity ward. These failings were exacerbated by the poor communication and left Mrs K feeling that she could not return to the maternity unit, despite being in significant pain. The Trust acknowledged and apologised for the communication problems but failed to understand the seriousness of the impact on Mrs K. It was unreasonable for the Trust to refuse to consider a financial payment for the distress caused by the failings.

Putting it right

The Trust apologised to Mrs K for its failings and paid her £1,000 in recognition of the distress caused. It also produced an action plan to address the failings identified.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Region

East

City or county

Essex

Summary 203/June 2014

Trust failed to diagnose husband's fractured hip

Mrs B complained to us that the Trust failed to diagnose Mr B's hip fracture. By the time the Trust identified the fracture, he needed a hip replacement instead of a repair.

What happened

Mr B was admitted to hospital after a fall. The Trust treated him with pain relief and discharged him to a 'step down' hospital to recover. When his pain continued, the Trust readmitted him and gave him a half hip replacement. When this failed, the Trust gave him a full hip replacement.

He sadly died some months after this.

Mrs B complained that the Trust had missed the hip fracture, gave the wrong treatment subsequently and as a result of this, Mr B quickly deteriorated and died.

What we found

The Trust failed to identify the hip fracture when it should have. We said that if it had been treated in good time, it is unlikely Mr B would have needed a replacement. We found the care and treatment after the Trust found the fracture to be reasonable. We said that we could not link the delay in diagnosis with Mr B's deterioration and death.

Putting it right

Mrs B and the Trust agreed with our report and accepted our findings and recommendations.

The Trust paid Mrs B £1,250 in recognition of the distress caused to her by the missed opportunity to treat her husband earlier, and for the subsequent poor complaint handling. It also produced an action plan to address the findings, identifying the lead and time frame for implementation and systems in place to measure the impact of its actions.

Organisation we investigated

Mid Essex Hospital Services NHS Trust

Region

East

City or county

Essex

Summary 204/June 2014

GP practice failed to provide adequate palliative care for older patient

Mrs C was suffering from a melanoma for which she had had radiotherapy. She was also suffering from vascular dementia, which was progressing quickly. Mrs C lived at home and her family and a carer were very involved in her day-to-day care.

What happened

In summer 2013, a Macmillan nurse told the Practice that the hospital was going to refer Mrs C to its specialist palliative care team because it had done all it could.

During that period, GPs from the Practice saw Mrs C because of her back pain and prescribed Oramorph (used to relieve severe pain).

The next month, the Practice received confirmation that Mrs C had been referred to the specialist palliative care service. On the same day, a doctor visited Mrs C at home. He noted that her family was worried that she was in severe pain. The doctor recorded that there was no spinal tenderness and that Mrs C's shoulders hurt when pulled at full-length movement.

Three days later the palliative care team saw Mrs C in her home. They agreed to liaise with Mrs C's oncologist (cancer specialist) about her back pain and suggested a scan of her spine. Mrs C had a fall that afternoon. When Mrs C was admitted to hospital, staff found that Mrs C's cancer had spread, particularly to her spine, causing some of her vertebrae to collapse.

The next month Mrs C was discharged from hospital into a nursing home, where sadly she died nearly two weeks later.

Mrs C's family complained that the doctor had been reluctant to visit Mrs C at home. They raised concerns about one particular visit. They said that the doctor who visited had seemed annoyed and had examined Mrs C roughly. They complained that he had told them that he was not convinced that Mrs C was in pain. They considered the doctor should have acted to address Mrs C's back pain.

The senior partner at the Practice responded to the complaint. He enclosed a letter from the doctor that outlined the care Mrs C had received. He disagreed with the family's version of the home visit. The senior partner's covering letter said that '*it looks as though we got this wrong on this occasion for which I apologise*'.

What we found

The Practice took a reactive approach to Mrs C's care. It failed to place Mrs C on its palliative care register, follow up on the referral to the specialist palliative care team or to put in place a plan for her management. The doctor's assessment, that Mrs C was not in pain, was incorrect.

These failings meant that the Practice did not have a discussion with her family about the approach it would take and the support that was available. This led to Mrs C's family feeling unsupported and distressed at seeing her in pain.

Failings in the Practice's complaint handling led to Mrs C's family feeling upset, angry and confused.

Putting it right

The Practice apologised to Mrs C's family and paid them £500. It also took steps to stop these failings happening again.

Organisation we investigated

A GP practice

Region

South East

City or county

Hampshire

Summary 205/June 2014

Trust agreed to assess psychological needs and to improve clinical documentation

Ms Y had bipolar disorder. Her mother complained that she was put at risk by being allowed to leave the ward and that she had been denied clinical psychology support.

What happened

Ms Y was detained under mental health legislation following an episode of illness related to her diagnosis of bipolar disorder. She was given permission to leave the ward on her own and was later found walking in the middle of a main road by police.

Ms Y's mother complained that her daughter had been put at risk by being allowed to leave the ward and also complained that she had recently had clinical psychology support withdrawn, possibly for financial reasons.

The Trust said that Ms Y's leave was reviewed and granted in line with Trust policy and procedures. It added that one purpose of leave was to assess the individual's progress as part of their recovery and if the leave did not go well, this was accepted as part of learning and positive risk taking.

The Trust said Ms Y had been assessed for psychological support and that it was found that she did not need psychological support from a clinical psychologist.

What we found

The decision to grant Ms Y leave was acceptable, as giving increasing periods of leave is important in testing a patient's recovery, and positive risk taking is sometimes required. However, this needs to be underpinned by adequate risk assessment. In this case there was little documentation to support decision making about leave and there was no evidence of any discussion about changes to risk that supported the decision to grant leave. This amounted to service failure and left Mrs Y concerned that her complaint was not properly dealt with as it was not based on the evidence available but about the reasonableness of her daughter's care.

There was no evidence to support the Trust's assertion that Ms Y had received an assessment that indicated that psychology support was not required.

Putting it right

The Trust took steps to address the accuracy of its clinical documentation and also agreed to provide Ms Y with a new assessment of her psychological needs.

Organisation we investigated

Southern Health NHS Foundation Trust

Region

South East

City or county

Hampshire

Summary 206/June 2014

Patient not warned about risk of scarring

Mr D complained about failings in the two minor surgical procedures that he underwent at the Practice and about its complaint handling.

What happened

Mr D visited the Practice to have a ruptured infected cyst removed from his face. Around a year later he returned to the Practice and had revision surgery on the same area where the scar from the previous procedure had formed. Mr D was unhappy with the results of his surgery and complained to the Practice.

What we found

The treatment provided by the surgeon at the Practice was appropriate. However, there was no evidence that the surgeon had warned Mr D about the risk of scarring.

The Practice failed to investigate Mr D's complaint or respond to his complaint in the 15 months or so between him first raising the complaint and when he complained to us.

Putting it right

The Practice apologised to Mr D and paid him £250 as compensation. As the Practice had already taken steps to address its failings, we asked it to share details of those improvements with Mr D.

Organisation we investigated

A GP practice

Region

London

City or county

Greater London

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 207/June 2014

Hospital changed patient's medication without informing GP, and failed to provide appropriate nutrition

Mrs F complained that the hospital changed her father's diuretic medication without telling his GP. Mrs F also complained about other problems.

What happened

Mr R was admitted to hospital via A&E in spring 2013. He had a number of medical conditions including Parkinson's disease, dementia, heart failure and pulmonary hypertension (raised blood pressure in the blood vessels that supply the lungs).

Mr R was diagnosed as being in urinary retention (inability to empty the bladder), and staff fitted a catheter. His diuretic medication (to treat his cardiac failure) was stopped, but the hospital did not tell Mr R's GP about this.

The speech and language therapy team advised that Mr R should be supervised when eating and drinking, and that he should be given a special diet of soft and mashed foods.

Mr R's specialist medication to treat his pulmonary hypertension ran out while in hospital.

After a stay of 15 days, the hospital discharged Mr R. After his discharge, he developed fluid retention and had to be readmitted to hospital eight days later.

What we found

The Trust failed to tell Mr R's GP that his diuretic medication had been stopped, and failed to appropriately communicate with Mrs F when she tried to find out what had happened.

The Trust failed to make sure that Mr R received food and fluids in accordance with the speech and language therapy team's instructions, and did not properly monitor his fluid intake.

Mr R's specialist medication for pulmonary hypertension ran out while he was in hospital. The Trust should have monitored what he had left so that it could order additional medication.

Putting it right

The Trust apologised to Mrs F for the failings in her father's care and its communication with her.

The Trust agreed to produce plans to prevent this happening again.

Organisation we investigated

University Hospital of South Manchester NHS Foundation Trust

Region

North West

City or county

Greater Manchester

Summary 208/June 2014

Ambulance trust's conflicting complaint responses caused grieving wife added distress

Mrs W complained about the actions of a paramedic who attended to her husband a few days before he died. In response, the Trust provided information that was both conflicting and confusing.

What happened

Mrs W made an emergency call when her husband, Mr W, experienced chronic back and abdomen pain, a week after having investigations for pancreatitis. Mrs W said that there was a delay of about two hours before an ambulance arrived.

She said that the sole paramedic, who arrived ten minutes after the emergency call, did not provide Mr W with pain relief, did not request urgent back up, did not carry out welfare checks and made Mr W walk to the ambulance. Mr W died of pancreatitis and septic shock three days later.

When Mrs W put her complaint to the Trust, she says that she experienced delays in receiving both updates and responses, and that the responses provided contained information which was contradictory.

What we found

The Trust apologised for the unacceptable delay in dispatching an ambulance. We found no evidence that this contributed to Mr W's death.

The paramedic should have chased up the whereabouts of the ambulance and asked for advice about possible further pain relief. Again, this was acknowledged and apologies offered. In addition, the Trust had taken appropriate steps to stop this happening again. Therefore we did not uphold these parts of the complaint.

While the Trust experienced staffing issues during the complaints process, it should have kept Mrs W informed about how her case was progressing. In addition, although the Trust answered all of Mrs W's questions, contradictory information, and changes to the complaints team, added to Mrs W's confusion and distress at a difficult time. This was not acknowledged adequately by the Trust and we upheld this part of the complaint.

Putting it right

The Trust wrote to Mrs W to acknowledge the conflicting information in its responses and to apologise for the confusion and upset caused.

The Trust also told Mrs W about the recent changes made to improve its complaint handling.

Organisation we investigated

East Midlands Ambulance Service NHS Trust

Region

East Midlands

City or county

Nottingham

Summary 209/June 2014

Failure to carry out root canal treatment

Mr Q wanted root canal treatment, begun overseas, to be completed in the UK.

What happened

Mr Q had root canal treatment on a tooth started in Poland. He visited the Surgery as a temporary filling had fallen out. Mr Q then returned to the Surgery several times to have further work carried out. Mr Q thought he was having root canal treatment from the Surgery, but it is not clear if this is what the Surgery thought it was giving him. Because of a lack of records, we could not determine what exactly had taken place at each appointment. Mr Q's final visit to the Surgery was an emergency appointment as the tooth the dentist had been working on had fractured. Mr Q returned to Poland to have the root canal treatment completed.

What we found

Mr Q had complained about a particular dentist at the Surgery. The dentist had failed to keep proper records of the treatment he had given Mr Q; failed to notice Mr Q was in the process of having root canal treatment on his tooth; failed to take X-rays and, when he did, took the wrong type; and prescribed Mr Q unnecessary antibiotics.

Putting it right

The Surgery apologised to Mr Q and paid him £250 compensation. It also produced an action plan to stop these failings happening again.

Organisation we investigated

A dental surgery

Region

East Midlands

City or county

Nottingham

Summary 210/June 2014

Patient's injuries were not properly explained

Mrs C was admitted to hospital with an existing wound to her leg. Her daughter complained that by the time she was discharged she had a pressure sore ulcer and a further injury to her left leg caused by a hot drink.

What happened

When Mrs C arrived at hospital she was assessed as having one existing injury on her thigh and a red sacrum. Six hours later staff recorded that all of Mrs C's pressure areas had been checked and were intact; however, this does not agree with the first assessment. Four hours after that, staff recorded the details of Mrs C's wounds. At this time, staff noted an additional wound.

What we found

Given the differences in the records, there are two possibilities for what happened. Either Mrs C was not thoroughly assessed when she was first admitted, or she suffered a further leg injury sometime between her admission and 11.30pm. This had not been accepted or explained by the Trust.

There was no wound care chart or care plan in Mrs C's records. Also, although the first assessment noted that Mrs C had a red sacrum, there is no further record of this. There is no evidence that Mrs C received appropriate pressure care.

Putting it right

The Trust apologised to Mrs C for the faults that we found and paid her £500 in recognition of the pain and distress she has experienced. It also produced plans to prevent the same failings happening again.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Region

East

City or county

Essex

Summary 211/June 2014

Failings in nursing care, although medical and surgical care was in line with established good practice

Mrs H said she was left with some pain despite a programme of treatment including medication and spinal surgery. She was also unhappy about nursing care she had received while in hospital.

What happened

Mrs H became unwell on holiday with severe pain in her arm. She returned home and tried to get treatment from her local hospital. Over the following months she received painkillers, injections and then two rounds of surgery to try to alleviate the spinal condition that was the source of her pain. This led to her spending a period of some weeks in hospital including staying during the Christmas period, when she felt the nursing care she experienced was very poor. Despite the treatment, she was left with some pain, which has affected her life.

Mrs H complained to the hospital, which said that her surgical care and treatment were appropriate. The Trust found some failings in her nursing care but did not say how it would improve services to prevent similar problems occurring again.

What we found

We saw no problems in the way in which Mrs H was diagnosed and treated. The reason for first trying painkillers, then injections and surgery only as a last resort was that surgery only alleviates the pain in some cases.

We agreed with Mrs H that her nursing care was poor and that, although the Trust had acknowledged some of this, it had not acted to put things right for other patients.

Putting it right

The Trust apologised to Mrs H for failings in nursing care and paid her £750 compensation. It also drew up plans to review all nursing documentation to make sure every patient is assessed when they arrive and that this leads to a personalised, effective care plan that is regularly evaluated; to review nursing handovers; and to review documentation used to monitor bowel function.

Organisation we investigated

Portsmouth Hospitals NHS Trust

Region

South East

City or county

Portsmouth

Summary 212/June 2014

Patient should have been prescribed stronger antibiotics and transferred to an acute hospital sooner

An older man was treated with antibiotics and kept in a rehabilitation hospital when he should have been recognised as very unwell and transferred to an acute setting.

What happened

Mr A underwent heart surgery. After the surgery, Mr A was slow to wake up, and when he did, he was essentially bed-bound and unable to talk. The Trust transferred him to a general ward at the acute hospital where his improvement was very slow. He was then transferred to a rehabilitation ward in a different hospital where he had a temperature and was breathless with poor oxygen saturation levels. After this, he was moved back to the acute hospital, where he died of bronchopneumonia.

His family complained that staff did not give antibiotics soon enough and that a delay in transfer back to the acute hospital caused Mr A's death.

What we found

There were failings in the choice of antibiotics and in how staff completed charts and acted on them. Staff did not recognise early enough that Mr A would have benefited from transfer to an acute hospital.

However, we did not conclude that these failings caused Mr A's death. We saw that Mr A was very unwell and concluded that different treatment or earlier transfer would, unfortunately, not have made any difference. Mr A had a severe and multiresistant pneumonia which did not respond to powerful antibiotics. His immune system was also impaired. This combination was very likely to have proved fatal, whatever treatment was provided.

Putting it right

The Trust apologised to Ms A for the failings identified and produced plans to improve antibiotic treatment and to make sure staff recognised situations when a transfer to an acute setting was required.

Organisation we investigated

South Warwickshire NHS Foundation Trust

Region

West Midlands

City or county

Warwickshire

Summary 213/June 2014

Lack of clarity about loss of jewellery

Mrs A's husband died in hospital shortly after an emergency admission. She complained that his rings went missing.

What happened

Mr A was admitted to hospital and died shortly afterwards. Mrs A was unable to see him before he died, but arrived soon afterwards. She is sure that he was wearing two gold rings, of sentimental value, and that she told the nurse that she would like them to remain on her husband's body for the funeral. The rings went missing. Mrs A complained about the Trust's failure to take care of the jewellery and the distress of having to pursue the matter at such a time.

What we found

The Trust did not follow its own policy and the relevant NHS guidance about safeguarding property. While there were differing accounts of the events, the Trust acknowledged its failure to provide evidence about what happened to the rings. The failure meant that Mrs A had to organise her husband's funeral without knowing what had happened to his jewellery. We saw that the Trust had already taken steps to remedy its deficiencies and was putting changes in place which we would have recommended.

Putting it right

The Trust apologised to Mrs A for the distress caused by its failings and paid her £1,000.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Region

West Midlands

City or county

West Midlands

Summary 214/June 2014

Community healthcare service gave insufficient physiotherapy to child with brain injury

A mother complained about the physiotherapy provided to her young daughter.

What happened

Miss B suffered a brain injury as a result of an illness. After six months in hospital and a rehabilitation unit she was discharged to the family home. For the first 14 weeks, Miss B received weekly physiotherapy from Medway Community Healthcare. This was then reduced to monthly sessions. Miss B's mother, Mrs B, complained about this reduction and also said that appropriate goals had not been set for the family to work towards. Mrs B also complained that Medway Clinical Commissioning Group (the CCG) misquoted her in a letter sent to her MP.

What we found

We partly upheld this complaint. It was right to reduce the frequency of Miss B's therapy after 14 weeks, but the reduction should have been to fortnightly in the first instance. There was a gap in realistic goal setting for the first five months after Miss B returned home. In addition, the CCG had not represented Mrs B accurately in a letter to her MP.

Putting it right

The CCG and Medway Community Healthcare apologised to Mrs B for the failings we had identified. The CCG wrote to Mrs B and her MP to correct or retract the inaccurate statements made about her. Medway Community Healthcare paid Mrs B £1,022 to recognise the fortnightly physiotherapy that had not been provided.

Organisations we investigated

Medway Community Healthcare

Medway Clinical Commissioning Group

Region

South East

City or county

Medway

Summary 215/June 2014

Failure in care and treatment at end of 84-year-old's life

Failure to provide appropriate end-of-life care meant that Mr F's symptoms were not as well controlled as they should have been. Poor communication caused his family distress, as did failures in looking after his belongings.

What happened

Mr F had advanced liver cancer and dementia, and lived with his son Mr E. After he became agitated and failed to recognise Mr E, Mr F was admitted to hospital. When Mr E visited him the following day, he found that some of Mr F's property was missing (clothes, a large amount of cash, and a pair of crutches). The hospital made no record of Mr F's property on his arrival, or when he was moved to different locations in the hospital. Some of the property was later found, but some remained missing. (Mr E said this included some of the cash.)

Mr F was discharged but was readmitted to hospital later the same month, just before a bank holiday. He was confused and agitated, and over the next few days nurses gave him medication to try to calm him. However, he was not seen by a doctor during the bank holiday weekend. After the bank holiday weekend, Mr F appeared over-sedated. Family members were concerned about the sedatives he had been given, and asked nurses and doctors about Mr F's condition and treatment. However, they were not satisfied with the information given. Mr F's condition deteriorated further and he sadly died.

What we found

The Trust did not follow its own property policy, and did not properly investigate or follow up the lost property or Mr E's complaint. This led to remaining uncertainty about what had happened, and Mr E could not be reassured that action had been taken to prevent it happening again or that hospital staff were not stealing from patients.

Because of poor documentation, we were unable to find out whether Mr F had arrived at the hospital with all of the property Mr E said he had.

End-of-life care specialists should have been involved in Mr F's care very quickly when he went back to hospital, but this did not happen. Mr F's sedative medication should have been given using a syringe driver (a syringe attached to a motor, which delivers medication slowly and steadily over the course of a day) rather than by single doses given irregularly. Overall, Mr F should have had more sedatives than he did. If that had happened, his symptoms of confusion, agitation and breathing difficulties might have been eased in the last few days of his life. However, the medication he was given did not hasten his death.

Doctors and nurses did not communicate clearly to Mr E that the end of Mr F's life was near, or about the care and treatment being provided. This caused unnecessary distress to Mr E as he could not understand what was happening, or why. It also worsened his grief following his father's death.

Putting it right

The Trust apologised to Mr E for its failings and paid him £1,300 compensation. It also developed a plan to learn lessons from the complaint.

Organisation we investigated

Luton and Dunstable Hospital NHS Foundation Trust

Region

East

City or county

Luton

Summary 216/June 2014

Trust failed to respond reasonably to complaint

The handling of Mr J's complaint was flawed and failed to reassure him that his concerns had been understood and addressed.

What happened

Mr J arrived at the Trust for planned surgery but was told the surgeon was not available and that it could not go ahead. There followed some disputed dialogue between Mr J and the Trust's admissions administrators that led to him being removed from the surgery list and referred back to his GP.

What we found

The Trust offered two responses to Mr J's concerns, both of which were poor. The Trust failed to acknowledge that Mr J had arrived for surgery and treated his complaint as a simple administrative error, failing to address some of his concerns.

The Trust initially also referred to supporting statements by staff that did not exist. The tone and wording of the Trust's responses did not reassure Mr J or us that it had recognised the nature of the complaint or done very much to address it.

Putting it right

We partly upheld Mr J's complaint. The Trust apologised to him and acknowledged that its previous responses did not fully or properly address his concerns. It also prepared an action plan to address the failings in its handling of Mr J's complaint.

Organisation we investigated

Barts Health NHS Trust

Region

London

City or county

Greater London

Summary 217/June 2014

Trust failed to adequately monitor patient

Miss A complained that her mother, Mrs A, was not monitored for eight hours and was found unresponsive after suffering a cardiac arrest. Miss A also had some specific concerns about aspects of her mother's care and about the way in which a consultant cardiologist approached the discussion of a do not attempt resuscitation order (DNAR).

What happened

Mrs A was admitted to hospital as she was more short of breath than usual. Staff gave her medication for heart failure and carried out two ECGs (to measure the activities of her heart). After further tests, the Trust started to treat Mrs A for a suspected heart attack and carried out a third ECG. Mrs A was transferred to a ward and nearly seven hours later was found unresponsive, having suffered a cardiac arrest (when the heart stops working). Cardiopulmonary resuscitation was successful and she was transferred to the intensive care unit. Eight days later she was transferred to a ward under the care of the consultant cardiologist. The consultant cardiologist spoke to Mrs A and Miss A about whether or not Mrs A should be resuscitated if she suffered a further cardiac arrest. Mrs A continued to receive treatment on this ward and another, before being moved the Trust's neurological centre. She later developed pneumonia and died.

What we found

Doctors did not realise that Mrs A was a high-risk patient and did not put in place a plan for continuous cardiac monitoring as they should have. After transfer to the ward, staff did not carry out any observations until after Mrs A's cardiac arrest. Although the decision to move Mrs A to a side room was reasonable, there is no evidence staff considered whether she needed one-to-one nursing during her periods of agitation; and relevant staff were not informed that Mrs A was nil by mouth when she had the scan. The consultant cardiologist did not explain that he did not feel that Mrs A should be resuscitated in the event of a further cardiac arrest in a sensitive manner to Mrs A and her daughter (although the decision itself was reasonable). Neither did he record his assessment of her capacity to contribute to the decision as he should have done. There was no evidence of a delay between when Mrs A was found unresponsive and the time of the cardiac arrest call.

How the Trust handled Miss A's complaint was maladministrative. These failings led to distress to Mrs A and her daughter.

Putting it right

The Trust apologised to Miss A for the failings and the injustice they caused. It agreed to put in place an action plan to address the failings it had not already addressed.

Organisation we investigated

Sheffield Teaching Hospitals NHS Foundation Trust

Region

Yorkshire and the Humber

City or county

South Yorkshire

Summary 218/June 2014

GPs missed opportunities to refer patient to hospital under suspected cancer pathway

A GP practice failed to recognise that a man in his sixties met the criteria for a two-week cancer referral.

What happened

Mr D's daughter, Miss D, complained that her father's GP Practice did not appropriately investigate his symptoms of pain and urinary tract infections over a nine-month period. Miss D said this caused her father's death because his cancer was undiagnosed for so long.

What we found

We partly upheld this complaint. There were no failings in the Practice's actions in the first seven months of Mr D's care. However, in the final two months the Practice missed two opportunities to refer Mr D to hospital under the two-week suspected cancer pathway. Although the diagnosis was slightly complicated by Mr D's long-standing medical problems, a number of symptoms indicated he had recurrent urinary tract infections. On the basis of Mr D's age, recurrent urinary tract infections and blood in his urine, he should have been referred to hospital on the two-week cancer pathway.

It was highly unlikely that Mr D's cancer could have been cured even if it had been diagnosed two months sooner. However, the Practice's actions meant that Mr D could not access end-of-life care as soon as he should have been able to. This caused distress to Mr D and his family, who will never know whether he could have lived longer or had a better quality of life if he had been diagnosed sooner.

Putting it right

The Practice apologised to Miss D and paid her £1,000. It also prepared an action plan to show how the Practice had learnt from the complaint.

Organisation we investigated

A GP practice

Region

Yorkshire and the Humber

City or county

York

Summary 219/June 2014

Hospital trust downgraded urgent referral for optical treatment

A patient waited four months for an urgent optical appointment.

What happened

Mr B was referred to the Trust for urgent care when his optician had concerns about his eye problems. The Trust downgraded the urgency of Mr B's appointment and he waited four months to be seen. Mr B's son complained about the decision to downgrade the urgency of the referral without getting further information.

What we found

The length of time Mr B had to wait for an appointment at the Trust was unreasonable and not in line with relevant guidelines. The Trust did not acknowledge these failings when it responded to the complaint. Our investigation concluded that these failings did not lead to a significant deterioration in Mr B's vision.

Putting it right

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

Organisation we investigated

Shrewsbury and Telford Hospital NHS Trust

Region

West Midlands

City or county

Telford and Wrekin

Summary 220/June 2014

Maladministration in overseas visitor charges but correct decision made

Mrs D complained that she should not have been charged for maternity care and that the Trust had been harassing her for payment.

What happened

Mrs D was charged for her maternity care. Her representative argued that she should not have been charged because under European case law she had the right to live and work in the UK as the parent of a European child. He additionally complained that the Trust had harassed her for not paying the charges.

What we found

It was likely that the Trust's decision to charge Mrs D was correct, but there was maladministration because the Trust had not fully considered the relevant guidance and it had not kept adequate records. It did not respond to the complaint from her representative in a reasonable way. However, it had not harassed Mrs D for payment.

Putting it right

The Trust told Mrs D what it would do to prevent similar problems from happening again.

Organisation we investigated

North Middlesex University Hospital NHS Trust

Region

London

City or county

Greater London

Summary 221/June 2014

Patient complained about attitude of receptionist and review of medication

Ms L complained the receptionist refused to issue her prescription to her and that her attitude was poor. She also complained that her medication had not been reviewed for a long time.

What happened

Ms L went to the GP to collect her prescription, having ordered a repeat prescription at the chemist. The receptionist could not find the prescription and Ms L left the building upset. The receptionist followed her out of the building to tell her she had found a note that said a repeat prescription could not be issued without a medication review by the GP. Ms L said the receptionist was rude to her and overstepped the boundaries of her role. She also complained that her medication had not been reviewed for many months, leading to mental health problems that now prevent her working.

What we found

We did not uphold the complaint about the receptionist. We said that as we did not witness the incident and there were two different accounts, it would not be reasonable for us to choose one account over another as being more accurate. The Practice properly investigated the complaint. We upheld Ms L's complaint that the Practice did not review her medication for a long time, but we did not find that it led to the injustice Ms L identified.

Putting it right

The Practice wrote a new policy on reviewing medication, intended to prevent the same mistake happening again.

Organisation we investigated

A GP practice

Region

West Midlands

City or county

Worcestershire

Summary 222/June 2014

Treatment delay, serious inconvenience, and frustration for patient

A woman with severe arthritis missed opportunities for her operations to go ahead because the Trust inaccurately recorded information and her complaint was not properly investigated.

What happened

Miss N needed an elbow replacement, which was to be done as two separate operations. The first-stage operation was cancelled and rescheduled twice because there was no bed available for her. Before the second operation, she went to several clinic appointments, waiting at least three hours to be seen at each one. Once Miss N was medically fit to have the second operation, after several months, the operation was cancelled because the operating theatre had not been deep cleaned, so there was an unacceptable risk of infection. A month after that, the operation finally went ahead. During that month Miss N went to a clinic appointment and waited an hour and a half to be seen.

Miss N complained to the Trust about the repeated cancellation of her operations for administrative reasons, and about the length of time she waited in clinics. She asked for financial compensation. After correspondence between them, Miss N remained unhappy with the way the Trust had handled her complaint. She complained to us about her experience at the hospital, and that the Trust's investigation of her complaint was not thorough or independent.

What we found

The Trust inaccurately recorded the first two cancellations, which meant that it could not prioritise Miss N properly when deciding whose operation to cancel. We could not say that her operations definitely would have happened, but there was a missed opportunity for them to have gone ahead as scheduled. The wait for the deep clean meant that Miss N's treatment was delayed by a month, so she had to wear a cast on her elbow for one month longer than necessary. The length of time she waited to be seen in clinics was unreasonable. This all caused serious inconvenience to Miss N.

The Trust did not fully and openly explain to Miss N what had gone wrong. Trust staff knew about the inaccurate reporting and that there were significant delays in clinics but did not explain this. The complaint investigation was not thorough because relevant electronic data about how long Miss N waited was not considered. Miss N was not told that the Trust had (internally) upheld her complaint. Her request for financial remedy was not properly considered. The investigation into part of her complaint was not independent because the investigating members of staff worked in the department responsible for managing cancelled operations and also fracture clinics.

Putting it right

The Trust apologised to Miss N for its failings and paid her £750. It is preparing plans to stop the same thing happening again.

Organisation we investigated

University Hospital of North Staffordshire NHS Trust

Region

West Midlands

City or county

Staffordshire

Summary 223/June 2014

Trust failed to compensate daughter for failings in her father's care

A daughter complained that her father received poor care in the final six weeks of his life.

What happened

Mr B was admitted to hospital with pain and immobility in his leg and hip. During the admission, the Trust diagnosed Mr B with cancer and other serious problems. Mr B later died. His daughter, Ms B, complained about several aspects of the care given to her father. Among her concerns were poor pain management; a lack of help with eating and drinking; a lack of investigations into Mr B's illnesses; failure to meet Mr B's cultural requirements; unexplained wounds and injuries; lack of respect; prescription of medication that made Mr B unwell; lack of senior medical review; delay diagnosing cancer and informing Ms B of this; and poor communication.

After a previous assessment of the complaint, we asked the Trust to give another complaint response, as the first one was inadequate. The Trust then apologised to Ms B and acknowledged several failings. It also explained a number of service improvements it had introduced. Ms B asked for a compensation payment but the Trust refused. Ms B complained to us as she did not consider that the apologies and service improvements were reasonable, and she was dissatisfied that the Trust did not award compensation.

What we found

There were failings in most of the issues Ms B put to us. The Trust had apologised for these failings and taken steps to stop the failings happening again and improve the overall standards of care.

The catalogue of failings had had a major impact on Ms B and worsened her bereavement. It was not reasonable for the Trust to refuse to pay her compensation. We partly upheld Ms B's complaint.

We did not think that the Trust had gone far enough in attempting to resolve Ms B's complaint.

Putting it right

The Trust paid Ms B £1,500.

Organisation we investigated

Royal Free London NHS Foundation Trust

Region

London

City or county

Greater London

Summary 224/June 2014

No delay in diagnosing cause of child's hip problems but Trust's handling of the complaint was inadequate

After Miss A's son was diagnosed with avascular necrosis (the death of bone tissue because of a lack of blood supply), Miss A complained about undue delay in the diagnosis and that the way the Trust handled her complaint about this was inadequate.

What happened

Miss A's son, P, had had treatment for septic arthritis (an infection in a joint), and had been having physiotherapy. After about three months, he was referred to a consultant orthopaedic surgeon with worsening hip pain. Several possible causes were considered but discounted and he was referred to a consultant paediatrician. Around the same time, P had an assessment of his walking. The surgeon was to arrange an MRI of his hip and spine. The paediatrician thought the pain was due to P's leg length discrepancy. The surgeon saw P again and he then had an operation to correct this. A month after the operation, P was discharged from physiotherapy, pain free. Three months later, the surgeon and the paediatrician both reviewed him. His hip was difficult to move without pain. P was referred for further physiotherapy to strengthen his joint. Two months later, he saw the paediatrician again following concerns from the physiotherapists about his pain and lack of improvement. The paediatrician arranged for tests; however, in the meantime P was admitted to hospital with severe pain. He was diagnosed with avascular necrosis.

What we found

Avascular necrosis should have initially been considered but was not. However, in the absence of a single agreed standard of good practice, we could not say that it was a failing not to carry out an MRI at that point. (An MRI helps with diagnosis in early avascular necrosis.) There was a missed opportunity to arrange an MRI following the assessment of P's walking. This was also a shortcoming. Due to the unusual presentation of P's avascular necrosis with pain-free periods, there were no further missed opportunities. The shortcomings did not amount to service failure.

However, we found maladministration in the way the Trust handled Miss A's complaint. The Trust admitted failings without considering whether there were failings, failed to put in place action to address the failings it had apparently found and failed to fully explain why, after all, it did not consider there were failings. The failings in complaint handling added to Miss A's distress following P's diagnosis of avascular necrosis.

Putting it right

The Trust apologised to Miss A and paid her £250. It also sent us details of the actions it was taking to make sure it met its complaint handling standards.

Organisation we investigated

Derby Hospitals NHS Foundation Trust

Region

East Midlands

City or county

Derby

Summary 225/June 2014

Communication failings in patient's end-of-life care

Mrs K expressed her concerns about her mother's pain relief and end-of-life care.

What happened

Mrs K was concerned about the treatment offered to her mother when she was admitted to hospital as an emergency. Sadly, within a week of her admission, Mrs K's mother died. Mrs K felt that the Trust could have done more to make her mother's death less traumatic for her and her family.

What we found

The Trust gave the family inaccurate information about the pain relief it had given Mrs K's mother. The Trust acknowledged that its communication around implementing the Liverpool Care Pathway was not good. However, the Trust did not explain how it would avoid this happening in the future.

Putting it right

The Trust apologised to Mrs K for its inaccurate response about pain relief. It also prepared an action plan to address its communication failings and to make sure that the views of all concerned are listened to, considered and documented when any end-of-life care plan is considered.

Organisation we investigated

Colchester Hospital University NHS Foundation Trust

Region

East

City or county

Essex

Summary 226/June 2014

Trust did not carry out medical review for almost 48 hours

Mr F was admitted to hospital following a second visit to A&E in 12 hours but his condition deteriorated. He died four days later.

What happened

Mr F was properly examined and assessed when he presented at A&E and when he was admitted to the ward. However, his diagnosis was uncertain and he had blood in his vomit so he should have been kept under medical review.

What we found

Mr F's care fell below acceptable standards and he was not medically reviewed for a period of 48 hours.

Putting it right

The Trust apologised to Mr F's daughter about what had happened. We would also have asked the Trust to pay her compensation, but she specifically said that she did not want a payment. The Trust produced an action plan to stop these events happening again.

Organisation we investigated

Pennine Acute Hospitals NHS Trust

Region

North West

City or county

Greater Manchester

Summary 227/June 2014

Clinicians carried out an appropriate attention deficit hyperactivity disorder assessment

Miss A's community mental health team psychiatrist referred her to Your Healthcare's adult attention deficit hyperactivity disorder (ADHD) service for an assessment.

What happened

A Your Healthcare consultant psychiatrist and a consultant clinical psychologist saw Miss A on three occasions and assessed her for ADHD. They noted that she presented with some symptoms of ADHD but there was not enough evidence to confirm this diagnosis.

Miss A's advocate complained to Your Healthcare about Miss A's assessment and the failure to diagnose the condition. The advocate questioned the clinicians' experience in dealing with ADHD cases. Your Healthcare replied that both clinicians were trained in the assessment and treatment of ADHD. The clinicians offered to meet Miss A to go through their assessment report.

Miss A was dissatisfied with this response and complained to us, via her advocate.

What we found

The assessing clinicians were suitably experienced and their process of diagnosis and assessment had been reasonable.

We did not uphold the complaint.

Organisation we investigated

Your Healthcare

Region

London

City or county

Greater London

Summary 228/June 2014

Prisoner wrongly believed that he had experienced significant delays in dental care when a trust handled his complaint poorly

A trust gave a prisoner wrong information when it responded to his complaint about the dental provider at a prison.

What happened

Mr V complained to the Trust that provided primary health care at the prison about delayed dental care. Rather than referring the complaint to the dental provider to address, the Trust responded to the complaint. Its complaint response was inaccurate, which led Mr V to believe that he had not been seen by a dentist when he should have been.

Mr V complained that the Trust had not responded to his complaint properly and that he had felt ignored and aggrieved.

What we found

The Trust could not show that it had co-ordinated a response to the complaint with the prison's dental provider (the NHS body responsible for handling the complaint under the NHS complaints regulations). The Trust's response was inaccurate and not evidence-based. Its complaint investigations and outcomes were not well documented or stored.

While there were no failings on the dental provider's part, the Trust's poor complaint handling led Mr V to think otherwise. He experienced distress and a sense of powerlessness as a result.

Putting it right

The Trust accepted it should not have responded to the complaint and that it had handled the complaint poorly. It agreed to apologise to Mr V and pay him £300. The Trust also agreed to review the way that it handles complaints.

Organisations we investigated

A dental provider

Leicestershire Partnership NHS Trust

Region

East Midlands

City or county

Leicester

Summary 229/June 2014

Dentist dealt with a complaint appropriately

Mr T had a new denture made. He was unhappy with the fit.

What happened

Mr T complained to his dentist about the fit and taste of his denture. The dentist adjusted the denture and gave advice on how to deal with the taste.

Mr T remained dissatisfied and asked for a refund, which the dentist declined to provide, but did offer to make further adjustments to the denture.

What we found

We did not uphold the complaint.

The dentist acted reasonably, and it was appropriate to have declined to provide a refund. We explained to Mr T that new dentures often need to be adjusted.

Organisation we investigated

A dental surgery

Region

South East

City or county

West Sussex

Summary 230/June 2014

Trust could not find a CT scan referred to in its response

A patient complained that his postoperative constipation was not treated, which resulted in diverticular disease.

What happened

Mr A underwent a successful kidney removal. He was then in hospital for five more days. He said he was not given adequate pain relief or protein drinks. He said he developed constipation, which was not treated adequately, and that this led him to develop bowel problems (diverticular disease).

The Trust said that CT scans done pre and postoperatively showed that Mr A had mild diverticulosis that had not worsened and which had not arisen because of his constipation. It apologised for the lack of protein drinks and explained how it had treated Mr A's pain and constipation.

What we found

The management of Mr A's pain and constipation was reasonable. We could not say that his postoperative treatment had caused his subsequent bowel problems.

We could only consider the preoperative CT scan (which showed mild diverticular disease) as the Trust was unable to provide the postoperative CT scan (or a report on it), even though it had referred to this in its response. This left Mr A unable to have an independent view of the response, which was clearly frustrating.

We also felt the Trust had not taken enough action to make sure staff gave patients their high energy drinks.

Putting it right

The Trust agreed to apologise to Mr A for being unable to provide the scan, and pay him £200. It also agreed to take steps to make sure patients get their high energy drinks.

Organisation we investigated

Medway NHS Foundation Trust

Region

South East

City or county

Kent

Summary 231/June 2014

Failings in care and treatment given by nursing home

Mrs V complained that her mother, Mrs T, was not properly cared for at the nursing home and that the record keeping and communication were poor.

What happened

Mrs T was staying at the nursing home after she broke her leg. She was prescribed medication to prevent deep vein thrombosis, but her medication was wrongly discontinued. The nursing home then failed to spot and act on signs of deterioration and Mrs T sadly died.

Mrs V complained about her mother's care at the nursing home and said she thought her mother's death was preventable.

What we found

The nursing home wrongly stopped Mrs T's medication, but we could not say with certainty that this led to her early death. There were failings in the observation and care given to Mrs T so staff missed the opportunity for earlier treatment. The nursing home's written records were poor, as was its communication with the family. The nursing home carried out an inadequate investigation and did not acknowledge or learn from its failings.

Putting it right

The nursing home apologised to Mrs V and paid her £1,500 in recognition of the distress caused. It also changed its training and policies in order to stop this happening again.

Organisation we investigated

A nursing home

Region

London

City or county

Greater London

Summary 232/June 2014

Dentist's failure to take regular X-rays resulted in damaged teeth

Miss K's teeth were damaged because of failings in dental care over a two-year period.

What happened

Miss K saw her dentist several times a year as she had a high decay rate and frequently required fillings. In 2012 she developed problems with a denture, which culminated in the dentist referring her to her local dental hospital. At the hospital, staff took an X-ray that showed Miss K had multiple areas of decay below the gum line of many of her teeth.

What we found

The dentist did not take as many regular X-rays of Miss K's teeth as he should have done, and did not properly assess or treat her high decay rate.

Putting it right

The Practice apologised to Miss K and paid her £3,000. It also agreed to prepare an action plan to prevent similar failings.

Organisation we investigated

A dental practice

Region

North East

City or county

County Durham

Summary 233/June 2014

Trust failed to replace faulty pacemaker lead quickly enough

When Mr A experienced ongoing dizziness, there was an unacceptable delay before the Trust replaced a pacemaker lead that had been diagnosed as faulty.

What happened

Mr A was fitted with a pacemaker. He experienced various symptoms, including dizziness, and had tests to resolve these. Mr A remained unwell, despite adjustments to his pacemaker and the lead. His symptoms significantly diminished after the Trust replaced the pacemaker lead.

What we found

The Trust provided reasonable cardiac care to Mr A throughout the period in question, with the exception of the undue delay replacing the faulty lead.

Putting it right

The Trust apologised to Mr A and paid him £750 in recognition of the impact its actions had had on his quality of life. It also drew up plans to make sure the mistakes were not repeated.

Organisation we investigated

Colchester Hospital University NHS Foundation Trust

Region

East

City or county

Essex

EMBARGOED COPY
Not to be published in any form before 00:01 hrs on Wednesday 29 October 2014.
This means that no citation, publication or notification of the contents are allowed before the time shown, but does not prohibit approaches to interested parties before the time of publication.

Summary 234/June 2014

Patient could not speak to practice on the phone

Mr E complained on behalf of himself and his mother, saying they both have serious health problems but could never get through to the Practice on the phone to get an appointment.

What happened

Mr E said that he had problems getting through to the Practice to book an appointment for himself and his mother because Practice staff would never answer the phone. He said he and his mother could not visit in person because of their illnesses and the queue, which was out of the door every morning. He said the receptionists had been very rude to him. Mr E said the Practice had not answered his complaint and despite telling him it would make improvements, it had not.

What we found

The Practice had not made a formal response to Mr E's complaint and had not shown that it had made any improvements. Despite saying it would arrange staff training, it showed no evidence it had done so. The Practice said it had responded to Mr E's complaint and held a complaint meeting, when it had not.

The Practice had a clear problem with telephone access and had not shown that it had taken any action to make improvements. As a result of this Mr E and his mother could not get appointments, had been left stressed and in ill health and had had to visit A&E instead to get medical treatment.

Putting it right

The Practice paid Mr E and his mother £150 each to compensate them for the stress. It also produced a plan of action to show how it will make improvements.

Organisation we investigated

A GP practice

Region

London

City or county

Greater London

Summary 235/June 2014

Trust could not have prevented sad loss of unborn twin, but should have apologised for mistake

Mrs R was pregnant with twins. She complained about the care and treatment she received the day before she had an emergency caesarean section. One child, E, was live-born but the other, V, was sadly stillborn.

What happened

When Mrs R was pregnant, she went to an antenatal fetal assessment unit where staff carried out a number of observations. A recording of the fetal heartbeat and uterine contractions (CTG) was performed and it was considered that this showed reassuring features.

The next day a doctor was asked to review Mrs R in the early morning because the fetal heartbeat for one of the twins could not be found. Medical staff carried out an urgent ultrasound that showed that one twin had died. The next day Mrs R had an emergency caesarean. E was live-born, but sadly, V was stillborn. Mrs R complained that if she had received appropriate management, both of her sons would have been born alive.

What we found

We noted that the Trust had accepted that staff should have noticed that the CTG the day before the caesarean was picking up just one heartbeat. The most probable explanation for why only one heartbeat had been recorded was that V had already died. Therefore, we concluded that there was no evidence to show that the fault in Mrs R's care led to loss of V's life, or that the outcome would have been different if the fault had not happened.

However, we saw that the fault, on its own, caused Mrs R distress. Therefore we considered that the Trust should have provided a clear apology that it happened.

Putting it right

The Trust apologised to Mrs R.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Region

West Midlands

City or county

West Midlands

Summary 236/June 2014

Patient was concerned that his deteriorating health was caused by his recent anaesthesia

Mr B felt that he was given too much or the wrong kind of anaesthesia, but we did not find this was the case.

What happened

Mr B was anaesthetised. He felt that this had not been done correctly because afterwards he had a cut lip, pallor and a tremor. In the longer term, his memory and concentration deteriorated. The Trust said anaesthesia was short-acting and would have cleared Mr B's system within approximately 48 hours.

What we found

Care UK, the health service provider, did not tell Mr B that he had been given aminophylline during his surgery, or that this could have caused his tremor. It had not recorded why he was given aminophylline.

However, we could not link Mr B's longer-term deterioration in health with his anaesthesia.

Putting it right

Care UK apologised to Mr B for not recording why staff had given him aminophylline and for not acknowledging in its response that this could have caused his tremor.

Organisation we investigated

Care UK - Eccleshill NHS Treatment Centre

Region

Yorkshire and the Humber

City or county

West Yorkshire

Summary 237/June 2014

Hospital trust made reasonable diagnosis

Mr C wanted the Trust to make changes to his medical records about his diagnosis.

What happened

Mr C complained that the Trust wrongly diagnosed him as having suffered a seizure without any evidence. He said this was because of questionable information in his medical records from an earlier appointment. Mr C complained that no tests were carried out and no other diagnoses were considered. He said because of this, the DVLA took his driving licence away for a year.

What we found

The Trust made an appropriate diagnosis. We found no evidence that the seizure was diagnosed because of information relating to the earlier appointment. We did not uphold the complaint.

However, the doctor did not record all aspects of his discussions with Mr C at the earlier appointment. In particular he failed to remind Mr C to contact the DVLA because of suspected partial seizures. We upheld this complaint.

Putting it right

We reminded the Trust of the importance of records reflecting discussions with patients and also reminding patients to report any episodes of decreased consciousness to the DVLA.

Organisation we investigated

Guy's and St Thomas' NHS Foundation Trust

Region

London

City or county

Greater London

Summary 238/June 2014

Hospital wrongly discharged vulnerable 84-year-old patient to empty house

Mrs R complained that her late mother, Mrs F, was inappropriately discharged from hospital to an empty house, in a confused state, with no medication and with a catheter still in place.

What happened

Mrs F was admitted to hospital because of a urine infection. Staff gave her antibiotics. Her consultant said that she should stay in hospital for three more days so she could have more antibiotics and staff could monitor her. She was then to be discharged. For reasons that are unclear, Mrs F was discharged later the same day.

When Mrs R realised that her mother had been discharged, she asked a neighbour to check on her. The neighbour was worried about Mrs F because she seemed confused and still had a catheter in place. Mrs R spoke to the ward sister, who was concerned about why Mrs F had been discharged and who had arranged this. The ward sister explained that Mrs F's medical notes were not fully completed, and she should not have been discharged, especially with a catheter still fitted, and with no medication. An ambulance returned Mrs F to hospital, where she received appropriate treatment.

Mrs R complained about her mother being wrongly discharged from hospital. The Trust accepted that the discharge was inappropriate, and said that there was no documentation about Mrs F's discharge or who arranged/authorised it. The Trust said that it could not get to the bottom of how or why Mrs F had been discharged.

Mrs R was dissatisfied with the Trust's responses. She did not feel it had got to the root cause of what had happened, and had not made any changes to its discharge processes.

What we found

It was wrong to discharge Mrs F against the instructions of the consultant, and when she had a catheter in and no discharge medication. A doctor must have authorised the discharge, and instructed a member of nursing staff to arrange it. There is no documentation by either the doctor or nurse about this decision to discharge Mrs F. This was a failure to comply with Nursing and Midwifery Council standards about record keeping. The situation could have had very serious consequences for Mrs F.

The Trust had already taken a number of actions as a result of the complaint, including apologising for the distress caused, and discussing the incident at the relevant team meeting, at the ward manager's meeting and at the medical directorate physician's meeting, so that staff could learn from what happened. However, more should have been done to give reassurance that this could not happen again.

Putting it right

The Trust apologised to Mrs R for not taking enough remedial action as a result of her complaint.

It produced an action plan, setting out changes to be made to the discharge process. It also agreed to audit compliance with its electronic discharge notification process, and to take action if staff did not comply with the process.

Organisation we investigated

East Kent Hospitals University NHS Foundation Trust

Region

South East

City or county

Kent

Summary 239/June 2014

Busy A&E department did not clinically review man with signs of sepsis within a reasonable time

Mr L complained that staff at A&E failed to treat him with sufficient urgency during his admission.

What happened

Mr L went to A&E at around 8pm due to breathing difficulties. Staff started him on intravenous antibiotics at around 11pm and transferred him to the medical admissions unit in the early hours of the following day.

What we found

An assessment nurse saw Mr L within a reasonable time and took observations. However, these observations warranted an early clinical review because Mr L showed signs of sepsis. Instead, Mr L was not reviewed by a doctor for three hours.

While the overall clinical assessment was reasonable, the Trust failed to undertake a blood gas analysis. Had it done so, it is probable that Mr L would have been given oxygen sooner. As it was, he was in avoidable distress for a number of hours.

While the Trust had already apologised for the delay, it had not done enough to find out what went wrong or to learn from the incident.

Putting it right

The Trust apologised to Mr L. It reviewed the way that national early warning scores had been calculated in this case in order to find out why the scores were incorrect. The Trust told Mr L about its system for making sure that clinically urgent cases are seen in an appropriate timescale at very busy times, and about how this is monitored. It also agreed to produce an action plan to address its failings.

Organisation we investigated

East Sussex Healthcare NHS Trust

Region

South East

City or county

East Sussex

Summary 240/June 2014

GP did not make sufficiently detailed notes about consultations or make appropriate referrals

When Mrs A asked her GP to refer her daughter, B, for paediatric and mental health care, the GP did not make suitable referrals, or keep detailed notes. The GP's actions contributed to the delays Mrs A experienced in accessing suitable help for B.

What happened

Mrs A's daughter B was 15 and had several health problems and disabilities. She became unwilling to go to school after an assault by another pupil. Mrs A asked B's GP to refer B back to the paediatric service, but not to paediatrician Dr K. The GP did not note that B did not want to see Dr K again, and as a result referred B to Dr K. This was not acceptable to Mrs A, or B, and various delays occurred, some of which were caused by the Practice. B eventually saw an appropriate paediatrician, by which time she had not been to school for several months.

What we found

The GP did not make sufficiently detailed notes about some of the consultations with Mrs A. This led to unnecessary delays in B seeing a paediatrician, and a lack of appropriate information in some of the referrals he made for her.

The GP failed to make an appropriate referral to the children and adolescent mental health services for B.

Putting it right

The Practice apologised to Mrs A and put a plan in place to learn lessons from its failings and make sure they did not happen again.

Organisation we investigated

A GP practice

Region

South West

City or county

Dorset

Summary 241/June 2014

Poor nursing care resulted in inadequate pressure area management for terminally ill patient

Mr C had been diagnosed with lung cancer with spinal and liver metastases. After undergoing spinal radiotherapy in spring 2013, Mr C was transferred to Aintree University Hospital.

What happened

A couple of days after Mr C's admission to hospital, Mr C's family noticed a pressure sore on his sacrum and asked for a referral to the tissue viability nurse. Staff ordered a pressure relieving airbed for Mr C, but this took four days to arrive. Mr C's family said that during this time, his pressure sore became much worse.

Mr C was transferred to a hospice shortly after, but died two weeks later.

Mr C's daughter complained to the Trust about the nursing care provided. She was concerned about inadequate pressure area care for her father and that there was evidence of incorrect completion of medical records. Although she understood that her father's prognosis was poor, she considered his death happened sooner than expected because of the Trust's failings.

What we found

There were failings in the nursing care given to Mr C, particularly in relation to pressure area care. Although the Trust had acknowledged some of these faults, its response did not fully address these or provide assurances that appropriate actions had been taken to learn from this complaint. The Trust also failed to explain that nursing staff were responsible for faults identified in the pressure area care and not a healthcare assistant, as it had said in its response.

The Trust's record keeping was poor, which meant that we could not be certain what impact the faults had had on Mr C's condition. This means that Mr C's family have been left not knowing whether his care detrimentally affected his condition, which has added to their distress.

Putting it right

The Trust apologised to Mr C's daughter and paid her £500 in recognition of the distress caused, which was exacerbated by its complaint handling. It also produced an action plan to address the faults we identified.

Organisation we investigated

Aintree University Hospitals NHS Foundation Trust

Region

North West

City or county

Merseyside

Summary 242/June 2014

GP practice provided reasonable care but inappropriately removed patient from its list

Mr J complained about a failure to diagnose deep vein thrombosis (DVT). He also complained that the Practice considered he was aggressive when he asked for a repeat prescription, and removed him from its list.

What happened

Mr J went to the Practice three times complaining of tiredness and pins and needles. On the third occasion, his leg was swollen. The GP suspected DVT and referred Mr J to hospital. The hospital confirmed DVT and prescribed Mr J warfarin as an anticoagulant. This ran out two weeks later and Mr J asked the Practice for a repeat prescription. No face-to-face appointments were available that day, so a telephone appointment was arranged. Mr J did not receive a call that morning and he went to the Practice. He says that he had to insist on being seen, while the Practice says that he was '*aggressive*' in his demand to see the doctor. Mr J's medication was prescribed, but the Practice removed him from its list. It said that he was aggressive and that it had a zero tolerance policy towards such behaviour.

What we found

The Practice provided appropriate care in relation to Mr J's DVT, because he had not shown symptoms of this condition until the third appointment, when he had swelling in his leg. He was appropriately referred to A&E at this point.

We could not say if Mr J had been aggressive when he went to the Practice. But in any event, regulations require GPs to give a patient a warning before removing them from a practice list (unless doing so poses a risk to health or safety or where it would be unreasonable or impractical to do so). As there was nothing to suggest that these conditions applied in Mr J's case, it was not appropriate for the Practice to remove him from its list without warning.

Putting it right

The Practice apologised to Mr J that removing him from its list was not done in line with the regulations. It also amended its zero tolerance policy so that it accurately reflected these regulations.

Organisation we investigated

A GP practice

Region

East

City or county

Hertfordshire

Summary 243/June 2014

Mental health trust admitted to failings, but did not put enough in place to address shortcomings

Mrs C complained that she had not been able to access support when she had a mental health crisis and her key worker was on leave. The Trust carried out an internal investigation that was robust and acknowledged its failings. However, it did not fully implement its own recommendations.

What happened

Mrs C suffers from mental health problems and receives care from the Trust's community mental health team and a psychologist. At the end of 2011 Mrs C did not have a named care co-ordinator, and her psychologist was acting as her key worker. However, her psychologist went on leave unexpectedly. At the same time, Mrs C experienced a mental health crisis. She tried to access support through the Trust's out-of-hours service. Although she had some telephone discussions with Trust staff, they did not identify that her crisis was escalating and did not offer her a face-to-face appointment.

The Trust's own internal investigation identified that it had not provided appropriate care. It said that there was a failure in cover arrangements, that Mrs C did not have a named care co-ordinator, and that her crisis plan had been copied from her old records from a previous trust. The Trust also said that its investigation found that Mrs C's crisis situation had escalated over a number of days, without being adequately addressed, and that she had not been offered face-to-face contact. It made recommendations for improvements in the community mental health team to address these issues.

What we found

The Trust's investigation was robust, identified the failings in Mrs C's care, and made reasonable recommendations aimed at addressing these failings. However, when we looked at how the Trust had implemented these recommendations, we found that it had not put sufficient improvements in place.

Putting it right

We asked the Trust to apologise to Mrs C and acknowledge that it had not yet put improvements in place to address its failings. We asked it to show that it has robust cover arrangements in place and implement a procedure to flag repeated contact to the out-of-hours service and highlight any escalation of a crisis situation. We also asked it to show that it has implemented a suitable procedure to assess the need for face-to-face contact.

Organisation we investigated

Cornwall Partnership NHS Foundation Trust

Region

South West

City or county

Cornwall

Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

Follow us on

If you would like this report in a different format, such as DAISY or large print, please contact us.

ISBN 978-1-4741-1155-3

9 781474 111553