Under embargo until 00.01 Thursday, 22 October 2015

Parliamentary and Health Service Ombudsman

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

February and March 2015

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Contents

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Introduction

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

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

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

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

September 2015

Complaints about UK government departments and other UK public organisations

Report on selected summaries of investigations by the Parliamentary and Health Service Ombudsman: February and March 2015

Summary 743/February 2015

UK Visas and Immigration made a flawed decision and poorly handled an asylum seeker's complaint

Mr L complained that UK Visas and Immigration (UKVI) did not tell him that he should have applied in person to stay in the UK.

What happened

Mr L came to the UK in 2002 and claimed asylum. His claim was rejected. Mr L didn't contact UKVI again until 2010, when he applied in writing to stay in the UK. UKVI failed to answer follow-up letters from Mr L's representatives, and only replied when his MP took up his case in 2012. In July 2013 Mr L's representatives complained to UKVI that it had still not decided his application.

What we found

At the time Mr L applied to stay in the UK, people in his position had to apply in person. If UKVI had received Mr L's written application, it should have returned it to him. We thought it unlikely that UKVI actually received it in 2010. However, when Mr L's representatives re-sent the application seven months later, UKVI should have looked at it and told him how to apply in person.

Putting it right

Following our investigation UKVI reconsidered Mr L's case and granted him Leave to Remain until September 2017. It also apologised to him for its poor handling of his complaint, and the uncertainty and anxiety this caused.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 744/February 2015

The Student Loans Company gave student incorrect information

The Student Loans Company wrongly told a student that it could overturn the decision after his application had been turned down.

What happened

Mr L applied for student funding. He was ineligible by the time he submitted his application because he did not have eligible immigration status at the start of the academic year (the 'cut-off date').

He complained that when he called the Student Loans Company helpline he was given incorrect information about when he would need to have eligible immigration status. He also said the information was not on the Student Loans Company's website.

When Mr L appealed, the Student Loans Company told him it had some discretion to award funding even if a student did not have eligible immigration status at the start of the academic year.

Mr L claimed he had incurred significant costs because of the wrong information he was given.

What we found

The Student Loans Company had given Mr L incorrect information about the cut-off date in a telephone call, but that was after the cut-off date. But it had given Mr L the correct information about the cut-off date in an earlier call which was before the cut-off date.

We did not find that it was a failing that the website did not include all of the conditions for eligibility. However, the Student Loans Company was incorrect to say it had some discretion to award funding even if a student did not have the eligible immigration status by the cut-off date.

The failings we identified had not led to the costs that Mr L claimed. However, the Student Loans Company had caused him frustration and inconvenience by giving him incorrect information about its having discretion to overturn its decision not to grant funding.

Putting it right

The Student Loans Company apologised to Mr L for giving him wrong information about the discretion it had, and for the inconvenience and frustration this caused him.

Organisation(s) we investigated

Student Loans Company Ltd (SLC)

Summary 745/February 2015

Court failed to record the hearing of a case

Claimant in a court case wanted to know why the judge found in favour of the defendant, but discovered the court had failed to record the hearing. The claimant would never know the reason for the judge's decision.

What happened

Mr B started a claim in a county court which was a considerable distance from his home. He decided not to attend the hearing of his claim and relied on the papers he submitted to the court as he was entitled to do.

HM Courts & Tribunals Service's (HMCT's) guidance to staff in March 2011 instructed them to carry out frequent checks on recording equipment. This was as a result of one of our earlier investigations that showed that a claimant had been disadvantaged by the court's failure to record the hearing of his case because of faulty equipment.

But in Mr B's case, the county court did not carry out the necessary checks, and so staff did not know that recording equipment in two hearing rooms had failed to operate. This meant a number of cases, including that of Mr B, had not been recorded.

Mr B wrote to the court and asked why it had found in favour of the defendant, and the court suggested he ask for a transcript of the hearing. It was only then that the court discovered the faulty recording equipment and that his case had not been recorded.

What we found

The county court failed to follow HMCTS's guidance, and only conducted infrequent checks on the equipment. The situation was made worse by the court's lack of a robust system for tracking recordings of hearings sent to transcribers. We also found shortcomings in the way HMCTS handled Mr B's correspondence. That and the infrequent checks to the equipment was an error that caused injustice to Mr B, who will now never know the reason why the court found against him.

Putting it right

The county court had already put in place a more robust system for tracking recordings of hearings between staff and transcribers and was training more staff to check recording equipment. HMCTS had already sent out a further reminder to all courts to check recording equipment daily. At our recommendation the county court apologised to Mr B for the mistakes we identified and their effect on him, and paid him £500 compensation.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 746/February 2015

Cafcass was not helpful when arranging an interview

Mr J complained that a Cafcass (Children and Family Court Advisory and Support Service) officer interviewed his ex-partner at her home but did not visit him.

What happened

Ms C, Mr J's ex-partner, lived in the south east of England (where the Cafcass officer in this case was based), while Mr J lived over two hundred miles away. Mr J told the Cafcass officer he could not travel to meet her. Despite this, the officer arranged an interview with him at her office in the south east of England which Mr J could not attend, and so the meeting eventually took place by telephone. Mr J felt that the officer should have visited him at his home, as she did when interviewing his ex-partner.

What we found

We partly upheld this case. The Cafcass officer was not customer-focused and did not deal with Mr J helpfully.

Putting it right

Cafcass apologised to Mr J.

Organisation(s) we investigated

The Children and Family Court Advisory and Support Service (Cafcass)

Summary 747/February 2015

Border Force put in place reasonable measures to deal with IT fault affecting airport

Mr A said he waited two and a half hours to pass airport immigration control when he arrived in the UK because of a fault with Border Force's IT systems.

What happened

Border Force experienced an unforeseen technical fault, which affected its computer systems at the airports. It put in place measures to make sure it could still process people through immigration control but said that some passengers queued for up to two hours to pass through. Mr A said he had booked a cab, and had to pay additional waiting fees because of the delay. He wanted Border Force to reimburse him the extra cost he incurred.

What we found

We did not uphold this complaint. Border Force's role was to check all passengers passing through immigration control. The IT fault affecting Border Force was a one-off, unforeseen and an unavoidable problem which it has since resolved. It put in place contingency plans to address the problem, which were as effective as could reasonably have been expected. This meant that staff never stopped checking passengers through immigration control despite the IT fault. While some passengers experienced up to two hours' delay, we did not find this was because of Border Force's actions. The airport operator, not Border Force, was responsible for prioritising people in the queues to immigration control. We did not uphold Mr A's complaint that Border Force was at fault for the delay he experienced.

Organisation(s) we investigated

Border Force

Summary 748/February 2015

Cafcass failed to explain how information about a woman's son would be used before sharing it with her ex-husband

Ms D complained about the conduct of an adviser from the Children and Family Court Advisory and Support Service (Cafcass) who, she claimed, wrongly shared information with her ex-husband, and so breached Ms D's data protection rights.

What happened

During a meeting with the Family Court Adviser (FCA), Ms D shared information about her son and his need for speech therapy sessions. Ms D said she made an agreement with the FCA that this information would be kept confidential. However, the FCA subsequently shared the information with Ms D's ex-husband, the child's father.

Ms D said both her and her son's welfares had been put at risk by Cafcass' actions. Further to this, Ms D said there were several occasions, during telephone calls, that the FCA's conduct was unprofessional.

What we found

Cafcass are entitled to share personal information under the Family Procedures Rules. However, we found the FCA's decision to share this information with Ms D's ex-husband was made without the FCA being fully aware of Ms D's ex-husband's previous behaviour, and the possible consequences of its action.

Without written records or voice recordings we could not say exactly what was said between Ms D and the FCA. However, we were satisfied that Cafcass acknowledged and apologised for the upset caused.

Our role is not to determine breaches of data protection, so we advised Ms D to contact the Information Commissioner's Office if she felt this had happened.

Putting it right

Cafcass apologised to Ms D and paid her £100. This was in recognition of the unnecessary distress and anxiety it had caused her by sharing information with her ex-husband, without first making sure that Ms D understood how the information would be treated.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 749/February 2015

HMRC failed to help customer get his tax right

Mr T complained that it took HM Revenue & Customs (HMRC) too long to sort out his tax affairs. He also said that the Adjudicator's investigation of his complaint did not put things right.

What happened

Mr T left the UK to live abroad permanently. He wrote to HMRC in September 2008 to ask what he needed to do to settle his UK tax affairs. Mr T had to write many letters to HMRC over a period of three years to sort out his tax affairs and for HMRC to repay the tax he had overpaid. Mr T complained to HMRC and it accepted there had been some mistakes and delays in response to Mr T's complaint. It paid him compensation of £75.

Mr T asked for a larger sum of compensation and also wanted HMRC to recompense him for 'lost' interest while he was waiting for the overpaid tax to be repaid. Mr T complained to the Adjudicator's Office (which looks at complaints about HMRC). The Adjudicator decided that there was no evidence that HMRC had received Mr T's first letter. It also decided that HMRC could not have sorted out Mr T's tax affairs any earlier. It also said that the amount of compensation HMRC had paid Mr T was sufficient, and HMRC should not recompense him for the 'lost' interest.

What we found

There was evidence that HMRC had received Mr T's first letter. Under HMRC's service charter to customers, it should have helped Mr T get his tax right by giving him the advice he asked for when he left the UK. If HMRC had done so, Mr T would have had the opportunity to settle his tax affairs earlier.

We agreed with the Adjudicator that HMRC was right not to compensate Mr T for the 'lost' interest because this was not an actual financial loss that could be calculated.

Putting it right

HMRC paid Mr T a further £100 for failing to give him advice when he asked for its help to get his tax right.

Organisation(s) we investigated

HM Revenue & Customs (HMRC)

The Adjudicator's Office

Summary 750/February 2015

HMCTS did not cause unnecessary bailiff visit

HM Courts & Tribunals Service (HMCTS) court staff acted reasonably when issuing a certificate of judgment (an order to enforce a judgment). Some of HMCTS's correspondence handling could have been better; however it took satisfactory steps to put this right.

What happened

Mr and Mrs G were involved in court proceedings regarding a debt to a company. The matter was settled by a consent order (an agreement between the parties), but Mr and Mrs G stopped making payments, and the company applied to enforce the order.

Mr and Mrs G complained that HMCTS court staff wrongly issued a certificate of judgment in order to enforce the order, when no judgment had been made. As such, they believed they endured the stress of an unnecessary bailiff visit.

What we found

We did not uphold this complaint. We found failings, but HMCTS had already accepted and remedied these.

The matter was initially settled by the consent of all parties. However, the wording on the original consent order was contradictory and unclear about whether the court had made a judgment on the matter. Without a judgment, the other party should not have been able to apply to enforce the order without first returning the case to court. We found that, given the information available at the time, it was reasonable for the court staff to believe there was a judgment and issue the certificate of judgment allowing enforcement action. We took the view that the intention of the wording on the original consent order was a legal matter which would need to be addressed by the court.

HMCTS accepted some delay in handling Mr and Mrs G's letters. It apologised for this and offered them £50. We considered this to be a reasonable response.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 751/February 2015

HMCTS's policy on issuing guidance leaflets for getting transcripts of previous court hearings

Mr F complained about HM Courts & Tribunals Service's (HMCTS's) policy on issuing guidance leaflets to its customers, and about the information it gave him when it responded to his complaint.

What happened

Mr F wanted to appeal a decision made in a small claims court. He personally visited the court and asked for information on how to appeal. The court staff advised Mr F to fill in an appeal form and pay a court fee. Mr F submitted his appeal application, but it was rejected by a judge because he had not provided a transcript of the original hearing.

Mr F complained that HMCTS had failed to provide him with a guidance leaflet to explain how he could obtain a transcript and go on to appeal. Mr F said that the small claims court was used by people with little knowledge of civil law, and HMCTS should have provided the guidance leaflet to him as a matter of course. He said that he had visited another court and been told that it issues the guidance leaflets as a matter of course.

Mr F said he had provided the appeal form and paid the fee as he had been asked to do, and so could not understand why his appeal application had been refused.

Mr F completed HMCTS's complaints process and then referred the matter to us through his MP. In one of HMCTS's responses to the complaint, it gave Mr F inaccurate information about the whereabouts of his case file. HMCTS acknowledged this mistake and apologised to Mr F for this.

What we found

We did not uphold the complaint. HMCTS has a policy of issuing guidance leaflets when these have been requested by a customer. HMCTS also publishes all of its guidance leaflets online. We concluded that HMCTS's policy was reasonable, and we could not see any evidence that Mr F had specifically asked HMCTS for advice on how to obtain a transcript. We told Mr F that a judicial decision had been made to refuse his appeal application, and we cannot consider a complaint about judicial matters; Mr F would have to appeal that decision in the courts. We noted that HMCTS gave Mr F inaccurate information about the whereabouts of his court file, but HMCTS had already done enough to put matters right by apologising.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 752/February 2015

Highways Agency was not responsible for flooding

Mr J thought the Highways Agency's road improvements had caused significant flooding to his land. He first asked the Agency to look into his complaint, and then went to the Independent Complaints Assessor (ICA), which deals with complaints about the Department for Transport and its agencies.

What happened

In 2008 the Highways Agency widened a main road and removed a layby next to Mr J's land. Mr J complained about flooding to his land from 2008 until 2011. The Agency, with the help of an independent expert, looked at whether its road improvements had caused the flooding. The Agency found that some drains needed to be repaired or replaced, but that neither the drains nor the road improvements had caused the flooding. Mr J did not agree and took his complaint to the ICA. Nearly two years later, the ICA said it did not uphold Mr J's complaint.

What we found

The Agency took appropriate action to try to resolve Mr J's complaint. It took the issues he raised seriously, and asked an independent and suitably qualified expert to look at the matter. There was no evidence the expert was anything other than impartial. The Agency's response to the issues, based on the independent expert's findings, was reasonable.

The ICA's conclusions were also reasonable. But review of the complaint took too long and that caused Mr J a significant amount of concern and frustration. We found the Department for Transport was responsible for the delay.

Putting it right

The Department for Transport apologised to Mr J for the delay in completing the ICA's review and for the frustration and inconvenience that caused him.

Organisation(s) we investigated

The Highways Agency

Department for Transport

Summary 753/February 2015

Failings in the way the Legal Aid Agency handled an application for legal aid

The Agency wrongly assessed an applicant's eligibility for legal aid on two occasions, and caused him to pay fees that should have been publicly funded.

What happened

Mr G became involved in family court proceedings and paid his initial legal fees on a private basis. His circumstances then changed and he applied for legal aid. The Agency assessed Mr G's application and found his disposable income was too high, so it refused to offer him funding. Mr G complained and the Agency realised that it had not properly considered his change of circumstances.

The Agency agreed Mr G could be offered legal aid, but by then the proceedings had ended and Mr G had paid most of the fees. Mr G asked the Agency for compensation. It took the Agency some time to consider Mr G's claim because it was difficult to obtain information from his solicitor. The Agency eventually agreed to pay just over a third of Mr G's legal costs. Mr G was unhappy with the Agency's offer and asked his MP to refer the complaint to us. Mr G told us he should be compensated for all of his legal costs because he was ultimately eligible for public funding.

What we found

The law was clear and we decided that Mr G could not have reasonably expected to receive legal aid for his whole case from the outset. However, the Agency was correct in paying him some costs after he had applied for legal aid. We examined the Agency's calculation of this and found it had overlooked some of Mr G's legal costs. We decided the Agency should have considered these costs and we recommended it pay Mr G an extra £595 in compensation. We also recommended the Agency should apologise to Mr G and pay him £250 for the distress and inconvenience caused by its failings.

Putting it right

The Agency apologised to Mr G and paid him £845 compensation.

Organisation(s) we investigated

Legal Aid Agency

Summary 754/ February 2015

Appeal took two and a half years to be properly heard, but HMCTS had already apologised for this

Ms B complained that errors by HM Courts & Tribunals Service (HMCTS) caused delays in her child support appeal hearing being heard. She said she wasted legal fees; had to represent herself at important hearings; and was without child support payments from her ex-partner for longer than she should have been.

What happened

Ms B lodged an appeal against a decision made by the Child Support Agency in January 2012. A number of hearings took place, and in July 2014 the case was finalised. Throughout this time Ms B was in constant contact with HMCTS about when hearings were going to take place. A number of hearings were adjourned, either for more evidence to be provided or because not enough time was available.

Ms B complained to HMCTS. Part of her complaint was that the delay in her case being finalised meant that the set fee she had paid for legal representation had been wasted, because this ran out before the case concluded. HMCTS accepted that there had been some unnecessary delay, but said that the majority of the delay had been caused by the judicial decisions to adjourn the case, and the need for more the parties to provide more information. However, HMCTS apologised and offered Ms B £200.

What we found

We did not uphold this case because failings by HMCTS had already been accepted and put right. Any delay caused by HMCTS's administrative errors was not the main reason Ms B's appeal took so long to conclude. Her appeal was complex and required a number of adjournments to allow for more information to be submitted from all parties. When this information was not forthcoming, HMCTS referred the matter to the judge for their view on what should happen next.

There were times when the level of workload, and HMCTS's failure to act on judicial directions in a reasonable time, added to the delay. However, we did not agree with Ms B, as we could not be sure that if HMCTS's failings had not happened, that her appeal would have concluded while she still had the benefit of legal representation. With that in mind, we felt that the explanations and apologies HMCTS had already provided, together with the compensation of £200 was a suitable remedy.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 755/February 2015

Cafcass's repeated errors caused delay and distress

Ms R's case was being handled by the Children and Family Court Advisory and Support Service (Cafcass). It made numerous errors, including accidentally closing her case and failing to notify the court that a report would not be prepared in time for the hearing.

What happened

Ms R's child access case was switched to a new Cafcass office. There were delays during this process, and also problems with Cafcass' referral of the case to a contact centre to arrange contact sessions between the child and her father.

Due to changes in Cafcass' postal system, Ms R's case was then accidently closed, and therefore Cafcass did not write a report as ordered by the court. Once Cafcass became aware of the error, it failed to contact the court to tell it that there would be no report for the next hearing. The officer also failed to respond to several pieces of correspondence.

While Cafcass acknowledged and apologised for many of the errors, Ms R did not feel that she had been offered adequate explanations. She was also unhappy with the £250 Cafcass offered her.

What we found

Although Cafcass had acknowledged its errors, it had not taken into account the full impact of its actions on Ms R. Her frustration was increased because she had previously brought a complaint about Cafcass to us, which we had upheld.

Putting it right

Cafcass apologised to Ms R and paid her £750 in recognition of the distress and inconvenience caused.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 756/February 2015

Complaint about a Cafcass Family Court Adviser

Mr Y was involved in family court proceedings and was unhappy with the behaviour of an adviser from the Children and Family Court Advisory and Support Service (Cafcass) and their report to the court.

What happened

Mr Y applied to the family courts for contact with his children. Cafcass produced a report for the first hearing but sent this to the wrong email address. Mr Y did not receive the report until the morning of the first hearing. After the hearing a Cafcass Family Court Adviser (FCA) interviewed Mr Y to gather information for a second report. Mr Y was unhappy with the FCA's behaviour during the interview, and with the contents of both their reports, so he complained to Cafcass.

Mr Y told Cafcass it was unfair that he had not received the first report until the day of the hearing. When Cafcass responded to Mr Y's complaint it apologised for sending the report to the wrong email address. Cafcass also notified its information governance department about the incident. Cafcass told Mr Y that the FCA refuted his allegations about its behaviour.

Cafcass explained that if Mr Y wanted to challenge the FCA's professional judgment then he must do this in court. Mr Y was unhappy with the way Cafcass had responded to his complaint, so he asked his MP to refer the matter to us.

What we found

We did not uphold this case as Cafcass had already accepted the failings in relation to the report. Although Cafcass had sent Mr Y's report to the wrong email address, it had done enough to put matters right by apologising. The impact of Mr Y not receiving the report until the last moment was also lessened because the hearing the report had been prepared for had been adjourned for an entirely separate reason. We made no finding on Mr Y's complaint about the FCA's behaviour because there was no evidence to say whether one person's version of events was more likely than the others.

We agreed that the remaining issues raised by Mr Y were matters suited to the court. We told Mr Y that while we could look into complaints about Cafcass's administrative actions, we would not consider anything that the court was better placed to address.

We explained that the court ultimately makes decisions on what is in the best interests of a child, and the court is therefore the most appropriate place to challenge any recommendations made by Cafcass.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 757/February 2015

UKVI apologised for three year delay in dealing with application to settle in the UK

Mr M complained that UK Visas and Immigration (UKVI) unnecessarily delayed making a decision about his summer 2009 application to settle in the UK with his wife.

What happened

Mr M made an application to stay in the UK through UKVI's premium service, which has to be done in person and requires a large fee. UKVI could not decide Mr M's application on the day he made it because its computer records showed his wife had been married before, but Mr M had said she had never previously been married. When UKVI looked at the files, it appeared Mrs M had been married before and had sponsored a previous husband to join her in the UK. Mr M said that UKVI had mixed up his wife's records with another person with the same name.

What we found

UKVI had not mixed up his wife's records with another person but it was likely that someone had used Mrs M's identity fraudulently. UKVI should have investigated the matter, established Mrs M's marital status, interviewed Mr and Mrs M, and made a decision on Mr M's application much sooner than it did.

Because of the delay in deciding his application, UKVI granted Mr M discretionary leave to stay in the UK in 2014 rather than seeking to remove him. And, while Mr M had been waiting for a decision, he was still able to live in the UK unaffected by the delay.

Putting it right

UKVI apologised to Mr M for the delay.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 758/February 2015

UKVI apologised for delay on an asylum claim

Mr D complained that UK Visas and Immigration (UKVI) gave him contradictory information about what he should do to legalise his status. He was left in limbo and could not work while waiting for his immigration status to be decided.

What happened

Mr D was a refugee. In 2006 he returned to his home country for a month following the sudden death of some of his family members. On his return to the UK, his refugee status was removed. Mr D made further submissions to regain his refugee status and permission to stay in the UK in spring 2007. These went into the backlog of asylum cases being dealt with (known as the legacy backlog) and Mr D waited for a decision. In spring 2008 Mr D converted to Christianity and made another further submission on this basis. In autumn 2011, Mr D queried when and how his case would be resolved. UKVI told him to visit its Further Submissions Unit in Liverpool, which in turn told him to make a new asylum claim in Croydon. It was only when Mr D asked us to intervene that his claim was finally resolved in winter 2014.

What we found

UKVI should have decided Mr D's asylum claim three years sooner, by summer 2011. Had it done so, it would have granted Mr D asylum in the UK for five years, much earlier than it did. UKVI should not have rejected Mr D's autumn 2011 further submissions; it should not have advised him to make a fresh asylum application at its Croydon office; and it should have resolved his application after he had lodged a formal complaint about the contradictory advice he had been given. This caused Mr D a good deal of inconvenience.

Putting it right

UKVI apologised to Mr D. It also paid him £200 compensation for the frustration and expense caused by its delay and misinformation about how to legalise his immigration status. However, UKVI's mistakes did not prevent Mr D from working. He could have asked for permission to work at any time from late summer 2010 onwards.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 759/February 2015

HMCTS failed to explain why it could not respond to a complaint

Mr P complained that HM Courts & Tribunals Service (HMCTS) unnecessarily delayed providing his brother with a transcript of a previous court case, and refused to address Mr P's complaint about this.

What happened

Mr P and his brother Mr J were left a house by their mother. Mr P wanted to sell the house but when Mr J refused to move out of the property, the executor's solicitor took him to court. Mr J made an application for permission to stay in the house and was ordered to get a copy of a transcript of a previous court hearing so that the judge could make a decision. Mr J asked HMCTS for the transcript in autumn 2012 but he did not receive it until spring 2014.

Mr P received regular updates on the case from the executor's solicitor. However, he complained to HMCTS about its delay in providing Mr J with a copy of the transcript, as this affected the sale of the house. Mr P went through the complaints process correctly, but HMCTS refused to accept his complaint.

What we found

We partly upheld Mr P's complaint because although HMCTS was right to refuse to respond to Mr P's complaint because he was not a party to the proceedings, it failed to explain this to him.

Putting it right

HMCTS apologised to Mr P and paid him £50 compensation.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 760/February 2015

UKVI overturned a settlement decision before an appeal hearing took place, but still required an appeal fee

Mrs K applied to UK Visas and Immigration (UKVI) to settle in the UK. UKVI refused the application so Mrs B, her daughter, paid £140 for an appeal. But the refusal decision was overturned before the appeal hearing took place and so Mrs B felt she had paid the fee unnecessarily.

What happened

In winter 2012 Mrs K applied for entry clearance to come to the UK as a dependent of her daughter. In spring 2013 UKVI refused the application on the basis that she had not provided enough evidence of her links to the UK; her lack of necessary support in her home country; the worsening of her medical condition; and her financial support in the UK.

Mrs K appealed the decision and provided further evidence to address the reasons she had been given for refusing her application. Mrs B paid a £140 appeal fee to HM Courts & Tribunals Service (HMCTS). In autumn 2013 UKVI reviewed the case before the appeal hearing took place, and noted that Mrs K had addressed the reasons for her earlier refusal. UKVI overturned the original decision without the need for a hearing.

Mrs B complained that UKVI and HMCTS do not provide sufficient information about refunds.

What we found

We partly upheld this case as there were failings, but we saw no injustice. UKVI's original decision to refuse Mrs K's application was not flawed, and it overturned that decision on the basis of new information which was not included with the original application.

The appeal fee is not specifically to pay for a customer's appeal hearing; it is a contribution to the cost of the appeal system. As a result of making the appeal, Mrs K had her case reviewed and the refusal decision overturned. However, we found UKVI's website did not explain clearly enough the circumstances in which it makes refunds to customers. However, there was no fault in the information HMCTS provided.

We considered whether Mrs B or her mother suffered injustice as a result of UKVI's failings. We did not find that they did. While it would have been helpful to Mrs B to see on the UKVI's website that the appeal fee would not be refunded, we did not think that it would have resolved her complaint. Mrs B remained dissatisfied with the policy regarding appeal fees and refunds.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

HM Courts & Tribunals Service (HMCTS)

Summary 761/February 2015

Failure to explain the rules on giving notice to the court

Mr J complained that HM Courts & Tribunals Service (HMCTS) refused to refund his hearing fee even though he gave it the seven days' notice it required.

What happened

Mr J's case was due to be heard in the small claims court on the 20 October. When HMCTS wrote to him confirming the hearing it said it would refund the hearing fee if he gave notice that the case had been settled at least seven days before the hearing date. On 13 October Mr J told the court the claim had been settled, and he asked for a refund. HMCTS refused to refund the fee because it said he should have given seven days' notice, excluding the day of the hearing and the day he notified it.

What we found

Under the law and the rules under which HMCTS works, 'seven days' notice' has a special meaning, which is that the day of notifying the court and the day of the hearing do not count. Therefore, HMCTS was right in saying that Mr J did not give it enough notice to have his fee refunded. However, HMCTS should have explained this meaning in all the information it gave the public. The standard letter it sent to Mr J did not make this clear, and based on that, it was reasonable for him to think he had given the court enough notice to have his fee refunded. As Mr J's case was only settled on 13 October, and we were not satisfied it could have been done much sooner, it was unlikely that he could have given the court enough notice to get a refund. Nevertheless, the failure by HMCTS to clearly explain the rules on giving notice caused Mr J unnecessary frustration and annoyance.

Putting it right

HMCTS apologised to Mr J for not clearly explaining how it calculated periods of notice, and the frustration and annoyance this caused. It also reworded its standard letters to make sure that its rules were clearly explained.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 762/February 2015

Cafcass apologised for failing to update man on his case

Mr H made an application through Cafcass (Children and Family Court Advisory and Support Service) for contact with his son. He was dissatisfied with the service the Cafcass officer provided and complained about it.

What happened

Cafcass admitted that the officer had failed to turn up to a scheduled visit and failed to return at least one of Mr H's telephone calls. It apologised for these mistakes.

Although Mr H was also dissatisfied with some enquiries the officer made of his son's grandparents, Cafcass said that the officer was right to make those enquiries. It told Mr H that if he was dissatisfied with the nature or extent of enquiries the officer made, he could raise those issues in court.

What we found

We did not uphold this case. There were failings in the service the Cafcass officer provided, but we were satisfied that Cafcass had already apologised for these mistakes.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 763/March 2015

Student Loans Company's error led to overpayment

When Mr G applied for student funding, the Student Loans Company (SLC) made an error so the grant he got was higher than it should have been.

What happened

Mr G applied for income-assessed student finance in the second year of his degree course. The SLC did not properly input Mr G's family income and so paid him a maintenance grant more than twice what it should have been. It was not until Mr G applied for student finance in his third year that the error was spotted. He was not paid a grant in the third year to cover the overpayment.

In autumn of the third year, Mr G's mother complained to the SLC but because of an error, staff did not refer the complaint to the complaints team. Mr G's mother complained again early the following year and the SLC sent an email in response to her complaint, but she did not receive it. Mr G's mother contacted the SLC again in spring 2012 and it re-sent the email.

The SLC apologised to Mr G for its inputting error and paid him £200. It also paid the full grant for his third year, which meant recovery of the overpayment was deferred until after Mr G had completed his course.

What we found

We partly upheld this complaint. It was the SLC's fault that the overpayment occurred. But Mr G should have been aware that he had been paid too much because the grant payment was more than twice the amount he had received the year before. The £200 compensation and apology was an appropriate remedy for the worry and distress caused.

It was reasonable that the SLC decided to recover the overpayment, but we saw no evidence that it had considered or documented whether it should have used its discretion to write off the overpayment. The SLC told us what guidance it had in place for considering requests to write off an overpayment. We were satisfied it understood the discretion it had for writing off an overpayment.

It was unreasonable that the SLC did not respond to the complaint in autumn 2011. If Mr G's mother had not chased matters, she would not have received a response to the complaint. We found this caused inconvenience.

Putting it right

The SLC apologised for the poor complaint handling and the inconvenience this caused.

Organisation

Student Loans Company Ltd (SLC)

Summary 764/March 2015

DWP sent incorrect information to man's MP about outcome of a fraud investigation

Mr A was claiming the higher rate of disability living allowance but his disability was not severe enough to entitle him to it. The Department for Work and Pensions (DWP) prosecuted Mr A but he was not found guilty of all of the charges the DWP brought against him.

What happened

Mr A had been claiming disability living allowance for over 10 years because he had been diagnosed with motor neurone disease. In the application form he stated that he was unable to walk more than 100 metres without help and that he was in severe pain seven days a week. However, Mr A's motor neurone disease did not progress as expected.

After a tip off, the DWP investigated Mr A's activities. It recorded him playing golf, riding a bicycle and doing other things that did not match his stated mobility and care needs. After an interview under caution, the DWP mounted two prosecution cases against Mr A, one civil at a tribunal to decide his entitlement to disability living allowance, and one criminal at a court to decide whether he was claiming disability living allowance fraudulently.

The DWP told Mr A that he did not appear to have motor neurone disease. Mr A went to a neurologist, who told him he did not have motor neurone disease and may have been misdiagnosed. Mr A had another illness that was much milder and not terminal.

The tribunal decided that, based on the evidence, Mr A was not entitled to disability living allowance from 2001 and he was ordered to pay back the benefits he received.

The court found Mr A guilty of not reporting a change of circumstance, that is, that his motor neurone disease did not progress as expected. He was sentenced to prison and to repay the benefit overpayment. However, the court found Mr A not guilty of misrepresenting his disability for the purpose of claiming benefits.

Mr A's MP asked for information from the DWP on Mr A's behalf. The DWP told the MP that Mr A had been found guilty by both the court and the tribunal of misrepresenting his disability. This was wrong because Mr A was only found guilty of not reporting changes in his circumstances.

When Mr A complained about this, the DWP got things wrong again by sending further unclear information to the MP. The Independent Case Examiner (ICE), the second tier of the DWP's complaints process, then investigated the complaint but did not identify that one statement was inaccurate.

What we found

We partly upheld this complaint. We found that the information that the DWP gave to Mr A's MP did not accurately reflect the decisions made by the court and tribunal.

Putting it right

DWP apologised to Mr A and his MP for providing incorrect and unclear official information. ICE apologised for failing to spot the incorrect statement and put it right.

Organisation(s) we investigated

The Department for Work and Pensions (DWP)

Independent Case Examiner (ICE)

Summary 765/March 2015

UK Visas and Immigration failed to process an application for leave to remain because it lost the payment form

UK Visas and Immigration (UKVI) lost the payment form that Mr B sent with his application for leave to remain as a dependent relative, so it did not process it. Mr B could then not apply within the correct time frame. UKVI also handled the complaint poorly.

What happened

Mrs P complained on behalf of her father, Mr B, about his application for leave to remain in the UK as a dependent relative. She said that UKVI lost the payment page of Mr B's application, which meant that it did not accept it, and Mr B could no longer apply for leave to remain under the dependent relative criteria because of this. Mrs P said that UKVI made no effort to resolve the problem and failed to respond to her complaints about the payment form for almost a year.

What we found

UKVI did not act properly when processing Mr B's application for leave to remain as a dependent relative. But, on the balance of probability, we found that Mr B had enclosed a valid payment form. This error denied Mr B the chance to have his application considered in time, and resulted in the loss of his appeal rights. The UKVI then mishandled the complaint because it failed to recognise, acknowledge and respond to it within its service standards or any reasonable time frame. This denied Mr B the opportunity to have his complaint fully resolved, or to receive a remedy.

Putting it right

UKVI apologised to Mr B and agreed to reconsider, and waive the fee for it. It treated this as an in-time application, with full appeal rights. It agreed to refund the fee paid for Mr B's application, and paid compensation of £350 for the frustration and distress it caused. It also agreed to address Mrs P's outstanding queries about what systems UKVI has in place to make sure documents do not go missing.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 766/March 2015

No evidence that mediator behaved unprofessionally but there was poor complaint handling by HMCTS

Mr D participated in a mediation process. He said the HM Courts and Tribunal Service (HMCTS) mediator laughed at him and behaved unprofessionally.

What happened

Mr D took part in a mediation process because of a dispute with a local council. He was not happy with the process because he said the mediator and the other party in the mediation laughed at him. He took the matter back to court to be resolved. He lost the court case, and the judge ordered him to pay the other side's costs. Mr D wanted compensation because he felt the mediator had undermined the mediation process.

What we found

We partly upheld this complaint. There was no evidence that the mediator acted unprofessionally or conducted the mediation inappropriately. The evidence we saw showed the mediator followed the required process. However, HMCTS handled Mr D's complaint poorly. It failed to investigate his complaint properly and it did not address all the issues he raised. This caused Mr D frustration and as a result, he had to bring his complaint to us.

Putting it right

HMCTS apologised to Mr D for the frustration caused by its poor complaint handling.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 767/March 2015

Passport Office failed to manage the process to return documents

HM Passport Office (HMPO) failed to give Mr J meaningful information, or manage his expectations, when he asked it to return documents. It also mishandled a request, and failed to address his complaint appropriately.

What happened

Mr J complained about HMPO's handling of his passport application in spring 2014. He said that HMPO's poor handling of his request to return his supporting documents caused him to cancel a flight and hotel booking. Mr J complained to HMPO and asked 27 questions about how it had handled his application, which he said it did not satisfactorily answer, and it did not respond to his complaint within a reasonable timescale. He also complained that HMPO's offer to pay £350 compensation did not take into account the £97.50 fee he paid for the application.

What we found

We partly upheld this complaint. HMPO failed to give Mr J any meaningful information about the process, or timescales, that people could expect when they asked HMPO to send back documents they had sent it. This was maladministration. Also HMPO did not act properly when it handled Mr J's request for his documents to be returned urgently, which led to an injustice to Mr J because he had to cancel a flight and hotel booking at full cost and he was also caused considerable frustration and inconvenience.

There were further failings in the handling of Mr J's complaint, as HMPO missed the opportunity to resolve Mr J's complaint and gave him only a partial response to the questions he raised. In addition, HMPO failed to acknowledge receipt of the complaint within two weeks or give updates on its progress and only haphazardly engaged with Mr J directly. However, we found no failings in the handling, or processing time, of Mr J's passport.

Putting it right

HMPO had already recognised that its errors had caused Mr J financial loss and had remedied this injustice. However, in line with our recommendations, HMPO apologised further to Mr J, paid him additional £100 compensation, and responded to the 27 questions in his complaint. HMPO also agreed to publish accurate information on its website and relevant guidance about what customers can expect when they ask for the urgent return of supporting documents.

Organisation(s) we investigated

HM Passport Office (HMPO)

Summary 768/March 2015

Following through might have managed expectations

Mr C complained that UK Visas and Immigration's (UKVI's) decision about his stepdaughter's application was wrong. He said that UKVI's actions caused him and his family a great deal of distress. He also complained about the way UKVI dealt with his telephone and email correspondence.

What happened

In winter 2013, Mr C's stepdaughter applied for leave to remain in the UK. Mr C, a British citizen, was her sponsor. In early 2014 UKVI refused the application because there was insufficient evidence that Mr C and his wife had sole responsibility for his stepdaughter's care. Also UKVI said that Mr C failed to show evidence that he met the income threshold.

Mr C telephoned a visa section overseas and the Croydon contact centre frequently after the decision, and exchanged emails with both these offices. The overseas visa section told Mr C that he should appeal the decision, as did the Croydon contact centre. The Croydon contact centre also promised Mr C several times that staff would call him back but did not do so. In addition, the Croydon contact centre asked Mr C to moderate his language after he had called members of staff '*ignorant gits*'.

After Mr C got in touch, the visa section overseas reviewed its decision on Mr C's stepdaughter's application on several occasions and accepted further evidence from Mr C. Having done so, it advised Mr C that the issue of sole responsibility had now been met, but that the matter of the income threshold had not. Staff told Mr C that he could appeal the decision once a separate Home Office appeal about the legality of having an income threshold had been decided (the Home Office won its appeal about the legality of the income threshold in summer 2014) or his stepdaughter could reapply.

In spring 2014, Mr C told UKVI that he was suffering from mental health issues and that his stepdaughter had been self-harming. Therefore, UKVI invited Mr C to provide further evidence that he met the income threshold. UKVI's records indicated that Mr C provided pay slips, bank statements and an employment record.

Later in 2014, UKVI accepted the further evidence that Mr C provided and granted his stepdaughter's visa.

What we found

We partly upheld this complaint. Having obtained the Home Office file, we could not track when Mr C had sent supporting evidence to UKVI. However, it was evident from the date of certain documents, such as a P60 from 2014, that Mr C had supplied evidence sometime after making the application in winter 2013. We also noted that UKVI's records stated that Mr C had sent it additional information after the application was made and that UKVI recorded that it was not until he sent particular documents in early summer 2014 that the Immigration Rules had been met with regard to income threshold. On the balance of probability, therefore, we considered it was likely that UKVI's original decision to refuse the application was not unreasonable.

In relation to Mr C's communication with UKVI, he was advised to appeal the decision on his stepdaughter's application if he disagreed with it. That advice was appropriate.

It was not surprising that Mr C was confused about how to proceed with his stepdaughter's case. UKVI told Mr C to appeal the decision when the issue of sole responsibility and income threshold was not met. They then told him the application would be put on hold when only the income threshold was not met and then advised him he could reapply. While telling Mr C this, UKVI also reconsidered its decision several times.

Having said that, UKVI reconsidered Mr C's case when it was under no obligation to do so. The fact that it did this meant that Mr C's stepdaughter did not have to appeal the decision or make a further application, both of which would have taken time and money. Therefore, Mr C ultimately benefitted from UKVI's reconsiderations.

UKVI responded to Mr C's emails and telephone calls in a timely manner and staff were polite and courteous to him. It was appropriate for UKVI to warn Mr C to moderate his tone and language when he made personal comments about staff.

However, there were occasions when the Croydon contact centre promised to call Mr C back and did not do so, causing Mr C frustration and distress. It would have been better if UKVI had followed its complaint guidance and advised Mr C that his comments would be passed on to the overseas visa section, which would respond. Nevertheless, we accepted that the Croydon contact centre had already apologised for not ringing Mr C back when staff said they would.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 769/March 2015

Poor communication by UK Visas and Immigration

Mr L complained that UK Visas and Immigration (UKVI) should have granted him two years leave so that he could meet the necessary level of knowledge of language and life in the UK. He said that a judge at his immigration tribunal had highlighted this. Mr L said that because UKVI had not done what the judge said, he had suffered deep depression, stress and anxiety.

What happened

Mr L first came to the UK in 1997. In late summer 2011 he applied for settlement on the basis of long residence. UKVI did not accept that he had provided evidence that he had lived in the UK for 14 years, and refused his application. Mr L appealed that decision. At the tribunal hearing in early 2012, the judge found that Mr L had provided evidence that he had lived in the UK since 1997, but he had not attained the level of knowledge of language and life in the UK to be granted settlement. The judge dismissed the appeal, but said that UKVI should 'bear in mind' that Mr L could be given two years leave to meet the knowledge of language and life in the UK requirement.

After the hearing, Mr L's representatives contacted UKVI, who told them his case would be sent back to the casework team for further action or consideration. However, UKVI staff took no action. Mr L sent UKVI evidence of English language qualifications, and his representatives and MP contacted UKVI to ask for updates on his position. However, it was not until early 2014 that UKVI told Mr L's representatives that he needed to make another application for settlement.

When Mr L complained to us, UKVI looked at his case again and granted him two more years leave so that he could apply for settlement. UKVI said that its decision took into account the time that had passed, and did not mean it would have reached the same decision if it had made it earlier.

What we found

We partly upheld this complaint. The judge's statement that Mr L could be granted an extension of stay in order to satisfy the requirement of knowledge of language and life in the UK was a comment, not a determination that UKVI was bound to follow. We did not therefore think UKVI was wrong not to grant him two years leave. However, despite telling Mr L's representatives it would review his case, it did not do so, nor did it give him a proper response about his position. We did not think UKVI would have made a positive decision if it had looked at his case, as it had no application to consider. But it was likely that UKVI would have told him he needed to make an application for settlement, and that his application would have been successful. Although Mr L lost that opportunity, UKVI largely put that right by granting him two years leave to remain in the UK. The fee for applying for settlement has increased since 2012 when the judge made his decision. However, other than some uncertainty caused by UKVI failing to give Mr L a proper response, we did not find that the stress and anxiety he suffered was the fault of UKVI.

Putting it right

UKVI apologised to Mr L and allowed him to submit an application for settlement and pay the fee that applied in 2012.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 770/March 2015

Ofsted's complaint handling needed to go further

Ms T was concerned about the attitude of an inspector from the Office for Standards in Education, Children's Services and Skills (Ofsted) during an inspection. She felt Ofsted did not handle her complaint about this in a reasonable way.

What happened

After an Ofsted inspection of her nursery, Ms T complained to Ofsted about the inspector. Ms T said she and other staff felt the inspector had not listened to them and had been dismissive. She also complained that the inspector had not met the requirements of Ofsted's guidance.

Unhappy with Ofsted's response to her complaint, Ms T then complained to Ofsted's adjudication service. She told the adjudicator that other nurseries had complained about the same inspector. When the adjudicator told Ofsted about these other complaints, Ofsted took no action.

What we found

We partly upheld this complaint. Ofsted's response to Ms T's complaint about the attitude of the inspector was reasonable overall. But it would have been better to have clarified with her the extent to which she was unhappy about the inspector's attitude.

Ofsted should have considered Ms T's comments about the other, similar complaints once it was aware of them.

Putting it right

Ofsted considered Ms T's comments about the other complaints, although this did not change its decision.

Organisation(s) we investigated

Office for Standards in Education, Children's Services and Skills (Ofsted)

Summary 771/March 2015

Information regulator failed to properly assess data protection complaints

Mrs N complained to the Information Commissioner's Office (ICO) about data protection complaints she had made to an NHS trust and a local authority. ICO did not properly assess all of her complaints.

What happened

Mrs N asked an NHS trust and a local authority for a copy of the information they held about her. This type of request is a 'subject access request'. Mrs N complained to ICO about the subject access requests and about her personal information being disclosed. ICO assessed the complaints, but Mrs N was unhappy with both of the assessments and asked us to review the decisions.

What we found

We partly upheld this complaint. The ICO did not properly consider all of Mrs N's complaints about the NHS trust in the assessment. However, it considered the complaints when it finished its internal review of its decision.

The ICO did not address Mrs N's complaint about the local authority in either the assessment or the review. Mrs N had not had a view from the ICO about whether the local authority had complied with the *Data Protection Act 1998*. This caused Mrs N frustration, inconvenience and upset.

There was an unreasonable delay in the ICO completing its review, because the review was not reassigned after the person originally responsible went on leave. The ICO's delay in completing the review caused Mrs N frustration and upset. However, the ICO's apology for this was adequate.

Putting it right

ICO apologised to Mrs N for failing to properly assess the complaint about the local authority. It agreed to review its handling of the assessment to see whether there was anything more it could do on the information request made to the local authority.

Organisation(s) we investigated

Information Commissioner's Office (ICO)

Summary 772/March 2015

HMRC kept giving incorrect information

Mr J wanted HM Revenue & Customs (HMRC) to tell him correctly what tax he owed so he could pay it, but it failed to do so. HMRC mishandled Mr J's tax affairs, causing him to underpay tax. When he asked for it to correct this, it gave him incorrect explanations and made wrong decisions.

What happened

Mr J complained that HMRC had not handled his tax affairs correctly, which had led to an underpayment in tax. He asked HMRC to tell him how much tax he owed in spring 2011, but he did not receive a response to this request. In autumn 2012 HMRC told Mr J that he owed over £2,300 in tax. Mr J asked HMRC to waive this tax under Extra Statutory Concession A19 (this allows HMRC to not collect arrears if it delayed notifying the taxpayer that there is underpaid income tax, capital gains tax or Class 4 NIC). HMRC agreed to waive some of the tax due, but still asked Mr J to pay nearly £1,500.

Mr J said he had not received a satisfactory explanation of why the provisions of the concession did not apply in his case. Mr J said he had a reduced pension income, and had therefore been affected both financially and emotionally by this matter. Mr J wanted HMRC to give up the remaining tax that he had been asked to pay.

What we found

We partly upheld this complaint. HMRC carried out at least three full reviews of Mr J's complaint: one at tier 1 of its complaints process, one at tier 2 and one when preparing a report for the Adjudicator's Office, which handles complaints about HMRC. On every occasion, HMRC got something wrong. It contradicted itself to the point where it no longer knew which response was correct. HMRC's reviews did not explain properly: how the underpayment for 2010-11 arose; which parts of the underpayment arose because of its mistakes; which part of the underpayment it was giving up; why it had to consider each part of the underpayment separately; and why it could not give up the remaining tax due.

Disappointingly, the Adjudicator's Office failed to spot these failings and correct HMRC's explanations. We therefore decided that HMRC and the Adjudicator's Office had failed to explain their actions properly and had failed to put things right.

Putting it right

Although HMRC had already given up some parts of Mr J's underpayment, some of those decisions were incorrect. These incorrect decisions compounded Mr J's confusion about why it refused to give up some other parts of the 2010-11 underpayment, and he needed this to be clarified.

As we had identified that HMRC's explanations of 2010-11 were unclear and incorrect, we asked it to carry out a further review for us. We then considered its responses and were satisfied that they were now correct. We also asked HMRC to waive part of Mr J's tax under the concession, which it should have done in the first place.

However, we found that even if an underpayment of tax is caused by HMRC, that tax is legally due and remains payable. The error is a delay in telling the taxpayer to pay, and not that the tax is not due. Even when HMRC makes such mistakes, the tax must be paid. In rare occasions such as in this case, part of the tax due can be waived if certain conditions are met.

HMRC apologised to Mr J for having repeatedly given him incorrect information. It refunded just over £53 of his 2010-11 underpayment, which represented the part that arose due to its failure to act on information. In addition, HMRC sent Mr J a formal notification showing his settled liability for the 2008-09, 2009-10 and 2010-11 tax years. It also paid Mr J a further £100 (on top of the £150 it had already paid) to acknowledge the errors identified in our report and the impact these had had on him.

The Adjudicator's Office apologised to Mr J for missing the opportunity to put things right for him.

Organisation(s) we investigated

HM Revenue & Customs (HMRC)

Adjudicator's Office

Summary 773/March 2015

Independent Case Examiner's investigation of a complaint was fair and reasonable

The Independent Case Examiner (ICE) found no evidence to support a complaint from a disabled student that she had been given the wrong information about benefits while studying at university.

What happened

When Ms N was due to start her university degree in autumn 2009, she visited her local Jobcentre Plus office to ask about benefits. She said she told Jobcentre Plus she was disabled and already received disability living allowance, but wanted to know if she could claim anything else. She said that Jobcentre Plus had told her she could not claim anything else. Ms N said that toward the end of her course in 2012, she had met another disabled student at university whose circumstances were similar. However, this student had received employment and support allowance and housing benefit the whole time she had been at university. Ms N said she had asked Jobcentre Plus to pay her backdated employment and support allowance and housing benefit because it had given her wrong advice. She said that Jobcentre Plus had refused her request. Ms N complained to ICE (the organisation that investigates complaints about Jobcentre Plus).

ICE investigated Ms N's complaint, but it was unable to find any evidence to support Ms N's account of events because any papers held by Jobcentre Plus were routinely destroyed after 14 months. It also concluded, on the balance of probability, that if Ms N had asked about benefits for disabled students Jobcentre Plus would have told her about employment and support allowance and housing benefit. Ms N was dissatisfied about ICE's decision to not uphold her complaint.

What we found

We did not uphold this complaint. Jobcentre Plus had indeed destroyed Ms N's papers as it had told ICE. But it was not possible to decide whether or not Ms N had been advised properly on the balance of probabilities because of the lack of any evidence. We concluded that the lack of any evidence at all meant we could not support Ms N's claim for the backdated benefits she wanted Jobcentre Plus to pay her.

Putting it right

We did not ask ICE to take any further action on Ms N's case, but we told it that while we agreed its decision had been right, we had found it not possible to decide Ms N's complaint on the balance of probability.

Organisation(s) we investigated

Independent Case Examiner (ICE)

Jobcentre Plus

Summary 774/March 2015

Border Force mishandled complaint about officer's behaviour

Border Force failed to investigate thoroughly Ms W's complaint about her treatment at Heathrow Airport.

What happened

Ms W came to the UK in late spring 2014 to study English to enable her to apply for a visa to come and live here with her British husband. Before being granted entry, she was questioned at Heathrow Airport about her proposed visit. She complained to Border Force about one of the officers' aggressive and intimidating behaviour.

Border Force investigated Ms W's complaint but the officer in question could not recall the incident, which had happened less than a month before. Therefore, Border Force was unable to substantiate Ms W's complaint.

What we found

Border Force's investigation of Ms W's complaint was poor. It made no effort to investigate Ms W's complaint further when the officer had said that she did not recall the incident. Even though another officer had been present when the officer had questioned Ms W, Border Force did not speak to her about the incident. Border Force made no attempt to establish if CCTV footage of the incident still existed. Although CCTV footage had no sound, it may have helped investigate the complaint because Ms W had said that the officer had been standing very close to her in an intimidating manner. Also, Border Force did not try to establish the identity of a senior officer who had been dismissive about Ms W's complaint at the airport.

Putting it right

Border Force sent Ms W a written apology and paid her £150 in recognition of the inconvenience caused.

It also agreed to review its guidance on complaint handling with a view to taking steps to improve its investigation of complaints.

Organisation(s) we investigated

Border Force

Summary 775/March 2015

Bracken dilemma left farmer out of pocket

A West Country farmer paid heavily after official guidance about bracken turned out to be only half right.

What happened

Mr H's land included cliff-top areas with some heavy bracken growth. Generally, his animals grazed on other parts of his land without bracken, which was poisonous. But for part of the year the cliff-top areas were suitable for grazing. Mr H's reading of the Rural Payments Agency's (RPA's) guidance was that he could claim an annual European Union farming subsidy for land where the bracken growth was thin enough for animals to graze. In 2010 an RPA farm inspection decided that the land was ineligible for subsidy. It recovered the subsidy it had paid Mr H in earlier years and imposed a fine that meant he received no subsidy for his 2010 claim. This caused Mr H shock and financial hardship, because he had had no time to prepare for the loss of income. He challenged the inspection decision and said RPA's guidance had misled him. But RPA upheld its decision.

What we found

We partly upheld the complaint. RPA failed to provide adequate written reasons for its decision in response to the challenge Mr H made in his appeal. Full reasons for the decision mattered because of the size of the penalty Mr H had to pay and because his next step in RPA's process would be costly legal action.

It was reasonable for Mr H to believe that bracken 'being grazed' by his animals was eligible and to base his view on the guidance specifically about bracken. RPA had a chance to acknowledge that, for Mr H, the guidance was unclear. Its own officials had acknowledged that it was unclear. But RPA chose not to apologise.

Putting it right

RPA agreed to apologise to Mr H, to give him a complete, written response to all the points he had made in challenging its inspection decision and to consider again whether or not its guidance misdirected Mr H and made him unduly vulnerable to suffering a penalty in relation to the bracken on his land. It agreed that it would compensate Mr H, if it decided it had misdirected him.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 776/March 2015

Small mistakes can have long-term consequences

Mrs D complained that Border Force stopped her at Manchester Airport in autumn 2013. She said that staff stamped her passport with two months leave to enter and advised her to legalise her immigration status.

What happened

Mrs D was a British overseas territories citizen through a connection with Hong Kong, and registered as a British National Overseas (BNO) before 1 July 1997. A BNO can hold a British passport and get consular assistance and protection from UK diplomatic posts. However, BNOs are subject to immigration control and do not have an automatic right to live and work in the UK. The EU does not consider BNOs to be UK nationals.

Mrs D was married to a British citizen. She applied for indefinite leave to remain in 2002 in her married name and included her marriage certificate with her application, but her passport was in her maiden name. UK Visas and Immigration (UKVI) input Mrs D's details on its case information database but did not include her married name. It granted her indefinite leave to remain in summer 2002. Its covering letter at the time (in her married name) advised her that she would need to provide evidence of her indefinite leave to remain once her passport expired, so she would need to take her expired passport with her when travelling.

Mrs D applied for a new British passport in 2002 and 2013. However, when she was returning to the UK from a holiday in autumn 2013, Border Force stopped her. She did not have her previous passport with her, but told Border Force she had lived and worked in the UK for over 20 years. There are no records of what actions Border Force took, but it told us that it was likely it could not locate Mrs D on its database but was persuaded that it was probable that Mrs D had the right to reside in the UK. Border Force stamped Mrs D's passport with two months leave to enter and advised her to legalise her status in the UK.

Mrs D contacted her MP, who told her to seek legal advice. Mrs D made enquiries to UKVI via her MP about the matter, but was advised it held no electronic records for her. In addition, UKVI advised her to apply for indefinite leave to remain and to seek independent immigration advice.

Mrs D applied for indefinite leave to remain in winter 2013 but UKVI told her that she already had indefinite leave to remain. It refunded her fee and advised her to obtain a biometric resident permit, which would confirm her immigration status for her.

An immigration minister responded to Mrs D's letters of complaint. He explained that when Mrs D applied for indefinite leave to remain in winter 2013, staff were unable to find her details because Mrs D's records were in her maiden name. He offered her £250 compensation for its handling of her case.

What we found

We partly upheld this complaint. As a BNO with no ID to confirm her immigration status to Border Force in autumn 2013, it was reasonable that Border Force stopped Mrs D. Also, because UKVI had not entered Mrs D's married name on its database in 2002, there was no way for Border Force to access her records and confirm that she had indefinite leave to remain.

However, we were critical of Border Force because its guidance specifically states that in situations such as these (where staff are satisfied that the passenger is probably legally resident in the UK) they should not stamp passports with two months leave to enter. Instead, staff should make an open date stamp and tell the passenger to provide evidence of their right to reside in the UK next time they pass through passport control.

UKVI failed to input Mrs D's married name into its database in 2002, in line with its guidance at the time. We considered that this had given rise to the events in 2013. However, we noted that UKVI told us that it had told Mrs D to seek immigration advice (which is often free of charge) not legal advice and that she had not told it in her correspondence that she had already legalised her immigration status with it in 2002. For these reasons, we did not consider UKVI should be asked to reimburse Mrs D's legal costs. We considered the £250 that UKVI had already offered was reasonable.

Putting it right

UKVI and Border Force both apologised to Mrs D for the faults we had identified in our report.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Border Force

Summary 777/March 2015

Jobcentre Plus failed to properly advise a jobseeker

When jobseeker Mr J said he wanted to claim for the cost of his travel to interviews, Jobcentre Plus did not tell him that he might not have all his costs reimbursed and that he would have to travel at his own expense.

What happened

Over a period of around four months, Mr J travelled to numerous job interviews and submitted claims to have his travel costs reimbursed by Jobcentre Plus under its Flexible Support Fund. Jobcentre Plus did not process most of his claims until several weeks after he had submitted them.

After he had been attending interviews for more than three months and had submitted claims for around 18 interviews, Jobcentre Plus told Mr J that there was a limit of five claims per person and that most of his claims would not be paid. Mr J complained that Jobcentre Plus led him to believe his claims would all be paid and that he had borrowed money for travel that he could not now pay back.

What we found

Jobcentre Plus's guidance said that when Mr J asked to claim under the Flexible Support Fund, Jobcentre Plus should have made sure that before he travelled, he knew that reimbursement was not guaranteed and that he would travel at his own expense.

Instead, Jobcentre Plus gave Mr J confusing and conflicting messages. Although one adviser mentioned a claiming limit to Mr J in an email, the adviser also gave Mr J the impression that all of his claims would be paid eventually.

Mr J complained to the Independent Case Examiner (ICE), which reviews complaints about Jobcentre Plus. It failed to identify that Jobcentre Plus had not properly advised Mr J and it too provided confusing and contradictory information.

Jobcentre Plus's guidance for managing claims under the Flexible Support Fund was unclear. The lack of clarity probably contributed to the confusing and inconsistent information Mr J received from Jobcentre Plus and, later, from the Independent Case Examiner.

Although we could not say that Mr J would not have attended so many interviews had he known his costs would not be reimbursed, the failure to properly inform him caused him inconvenience and denied him the opportunity to make an informed choice about spending money on interview travel.

Putting it right

Jobcentre Plus apologised to Mr J and made him a consolatory payment of £300. It also reviewed its guidance and took steps to make sure relevant staff were properly trained. The Independent Case Examiner also apologised to Mr J and made him a consolatory payment of £150.

Organisation(s) we investigated

The Independent Case Examiner (ICE)

Jobcentre Plus

Summary 778/March 2015

Environment Agency did not explain why it sent letter to director's home address

The Environment Agency had no policy or procedures in place when it sent a letter to a director's home address and failed to give him an adequate explanation of its actions.

What happened

Mr B was the director of a small company that was in dispute with the Environment Agency about how it was dealing with one of the company's products. The Environment Agency sent him a letter to his home address that told him he was in breach of the *Environmental Protection Act 1990*. Mr B complained and asked to see the Environment Agency's policy and procedures on writing to directors at their homes. He asked for its reasons for sending him the letter at home. There followed a long correspondence between Mr B and the Agency but Mr B remained unsatisfied by the Environment Agency's explanations.

What we found

We partly upheld this complaint. At the time that the Environment Agency sent Mr B a letter to his home address, there was no policy or procedure in place to advise on when and how to take this action. This was a failing. The Environment Agency also did not act properly when handling Mr B's complaint. Having discussed the case with the relevant Environment Agency officers, we concluded that even if there had been no failings and guidance had been in place at the time, it was more likely than not, on the balance of probabilities, that the Environment Agency would still have sent the letter to Mr B, so we did not find any injustice. However, he had been put to the annoyance and inconvenience of trying to get an adequate response to his complaint, and that was an injustice.

Putting it right

The Environment Agency apologised to Mr B for the annoyance and inconvenience. As a result of Mr B's complaint, the Agency produced guidance and agreed to amend it in light of our investigation to make sure that it explained to a recipient why it had sent a letter to their home address.

Organisation(s) we investigated

Environment Agency

Summary 779/March 2015

Wrong visa advice stranded man for two months

Mr W was prevented from returning to the UK from South America with a new passport. Wrong visa advice from embassy staff led to him being stranded for two months.

What happened

Mr W had indefinite leave to enter the UK. He and his wife, a British citizen, decided to visit South America but when he tried to board the plane with a new passport to fly back to the UK, the airline would not let him board. Visa staff at two British embassies incorrectly told them that Mr W's visa had expired and he needed to reapply for settlement. When he submitted a settlement application, they told him it was the wrong application and that he needed to apply for a returning resident visa, which he then did. He could then return to the UK.

What we found

We partly upheld this complaint. An airline has the right to refuse to carry a passenger if it is uncertain about their immigration status, so Mr W would have had to apply for a returning resident visa once the airline refused to let him board. However, he was misadvised several times by the visa staff at two different embassies and was mistakenly told to submit a new settlement visa. Errors by staff caused delay and a great deal of stress and anxiety. Mr W also lost about two months' earnings because he was unable to return to the UK and go back to work immediately after his holiday and both Mr and Mrs W struggled financially during that time.

Putting it right

UKVI apologised to Mr W, agreed to reimburse him £2,088 for his lost earnings and to make a consolatory payment of £1,000 in recognition of the distress and extra costs he incurred as a result of its mistakes.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 780/March 2015

Poor complaint handling exacerbated fiancé's grief over bereavement

Mr A complained that the actions of Border Force and UK Visas and Immigration (UKVI) contributed to the decision of his fiancée, Ms G, to take her own life in late 2011. Mr A also complained about UKVI's two subsequent refusals of Ms G's visitor visa applications earlier in 2011 and in 2012 (after her death). He said they left Ms G, who did not speak French, isolated in Paris for two months.

What happened

Ms G, an American national, tried to enter the UK via Dunkirk in 2011 with Mr A, a British national. Border Force searched Ms G including her sealed mail and found she had a prescription for antipsychotic medication for depression and a pamphlet on how to commit suicide. They refused Ms G entry because they had evidence from the Republic of Ireland that Ms G had been issued with a deportation notice, that she had inadequate evidence of funds to support herself and that she had medical issues, which according to Border Force guidance prevented her from entering the UK. Border Force made a note of its decision on the Home Office case information database.

Ms G travelled to Paris and submitted a visitor visa application to the British Embassy. UKVI refused this because it was not satisfied that Ms G was a genuine visitor who intended to leave at the end of her stay or that she had resources to support herself during her stay.

Ms G made another application, but died of an overdose before UKVI made its determination. Unaware of these events, UKVI issued a refusal notice on the basis that Ms G had not provided evidence of her accommodation in France or any assets there. UKVI noted that Ms G had no evidence of a return flight to the USA. UKVI said she did not show sufficiently strong family, social or economic ties to the USA or France to show that she intended to leave the UK. Lastly, UKVI noted that Ms G had no evidence of Mr A's passport and that he could accommodate her for the duration of her visit. UKVI noted that Ms G provided bank statements but she had not provided origin of her funds and no evidence that they were readily available.

Mr A complained to UKVI and Border Force. Both organisations considered they had acted appropriately with regards to Ms G.

Mr A's MP approached the Home Office minister with his concerns about both UKVI and Border Force. Mr A's complaint was passed to various senior staff. Eventually, he received only a partial response.

What we found

We partly upheld this complaint. There was no evidence that Border Force was prejudiced against Ms G and there were no grounds to question its decision to refuse her entry to the UK in autumn 2011. It had followed procedure in terms of reading Ms G's sealed correspondence.

However, Border Force failed to follow its guidance in relation to dealing with vulnerable people. In light of the evidence it found about Ms G's medication and suicide pamphlet, Border Force should have assessed Ms G's well-being. It failed to do so. However, even if Border Force had followed its most recent guidance on the matter, it was unlikely that it would have intervened, or changed its actions significantly.

UKVI staff at the embassy in Paris would not have known about Border Force's note on the case information database because they did not have access to it. However, even if UKVI had seen Border Force's note and followed its up-to-date guidance, staff were unlikely to have handled Ms G's case differently.

We had no grounds to question UKVI's reasons for refusing Ms G's visa applications. However, we were critical that UKVI destroyed the supporting documents that Ms G supplied with her application. Although it was UKVI's process to destroy such documents after 13 months, it was unreasonable to do so in this case, when there was an ongoing complaint.

Neither UKVI nor Border Force addressed all the points that Mr A raised in his correspondence with them. There were significant delays in UKVI and Border Force responding to his concerns. They failed to respond to a request he made for documentation from Ms G's case.

Putting it right

UKVI and Border Force both apologised for their handling of the complaint and each paid Mr A £350 in compensation. UKVI agreed to review its procedures for destroying supporting documentation from case files in the wake of an ongoing complaint. Both organisations agreed to complete their consideration of Mr A's request for documentation.

Organisation(s) we investigated

Border Force

UK Visas and Immigration (UKVI)

Summary 781/March 2015

Sorry, let me read that again

A complex subsidy scheme, a capricious computer system and an inexperienced member of the public – what could go wrong?

What happened

The Rural Payments Agency (RPA) gave Mrs W, who was in her seventies, wrong information in the years 2010 to 2012 after she contacted it about making her first claim for a European Union farming subsidy called the Single Payment Scheme (SPS). Her SPS entitlements had expired. But an RPA data error meant the computer system labelled the entitlements as still valid and this was the wrong information that RPA officials kept giving Mrs W.

What we found

We partly upheld this complaint. RPA made serious mistakes in its contact with Mrs W. When she contacted it in autumn 2010, its inaccurate and incomplete information misled her into believing that it had received a 2010 SPS claim in her name. Next, its data error added a false extra year to her SPS entitlements. This error misled RPA, Mrs W and her new representative into believing she could claim SPS for 2011. RPA started giving Mrs W and her representative accurate information only in early 2012.

If RPA had acted correctly, it would have told Mrs W when she called it in autumn 2010 that it had received no SPS claim in her name and that her SPS entitlements had expired. Mrs W and her husband could at least have considered buying more entitlements in time to claim SPS for 2011 and later years.

Instead, the incorrect information from RPA led Mrs W to make a wasted application for SPS in 2011 and to incur avoidable professional fees. But we found no link between RPA's mistakes and either Mrs W's lost opportunity to claim SPS for 2010 or the wasted effort of her 2012 SPS application.

Putting it right

RPA had already paid Mrs W £100 to apologise for the incorrect information it gave her. It made a further apology and consolatory payment of £250 and also agreed to pay a sum towards the professional fees she incurred because of its wrong information.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 782/March 2015

HMCTS failed to refund a fee

Mr D complained that HM Courts & Tribunals Service (HMCTS) had not refunded him a fee of £210 that he paid to issue a claim. Mr D believed he was due the refund because of his entitlement to benefits. He was also unhappy about HMCTS's general handling of his applications for a refund and the time it was taking to resolve matters.

What happened

Mr D issued a claim in early 2012 for a refund of the issue fee (£210) and the fee for the allocation questionnaire (£220). The £220 fee was refunded in winter 2012. However, it was not until spring 2013, and after Mr D had been referred to three different departments within HMCTS that staff told him that he was not entitled to claim a refund of the £210 fee because he had issued his claim online. HMCTS said this was in line with *The Civil Procedure Rules*. Mr D disputed this, but HMCTS maintained that its position was correct. On that basis HMCTS refused to refund Mr D the £210 fee and so he brought his complaint to us.

What we found

We partly upheld this complaint. There was evidence to show that Mr D had made his claim online as HMCTS had suggested and so he was not entitled to the £210 refund in line with *The Civil Procedure Rules*. However, HMCTS's handling of Mr D's application for the refund was poor. It had involved a number of departments within HMCTS, and this had confused matters and caused a delay of over a year before Mr D was told that he was not entitled to the refund because his claim had been made online. If he had been told this sooner, he would not have been put to the inconvenience of pursuing matters as he did.

Putting it right

HMCTS accepted that its handling of Mr D's application for a refund was poor. It apologised to him and paid him £200 for the distress and inconvenience caused.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 783/March 2015

Cafcass family court advisor made mistakes in report for court

Mrs W complained that the family court advisor assigned to her case had not conducted herself well during an interview with her two children. Mrs W was also concerned that the family court advisor was biased against her and had made a number of factual errors in her report to court.

What happened

Mrs W applied to court to have her two son's surnames changed. A family court advisor was asked to write a report and in preparation, she interviewed the boys at their home. The family court advisor's report had a number of errors because she had mixed up the boys' names. She accepted the errors and produced an amended report. However, Mrs W complained that there were further errors in the amended report, including a section where the family court advisor had referred to Mrs W's six-month-old son as having initiated the name change. Mrs W complained again to Cafcass, which maintained that the amended report was accurate and that disputes over opinion were for the court to determine.

The family court advisor recommended to the court that Mrs W's children should not be allowed to change their surnames. The court did not agree and instead allowed Mrs W's application.

What we found

We partly upheld this complaint. There was no evidence to suggest that the family court advisor had not acted in Mrs W's children's best interests. We also accepted Cafcass's view that there was a difference of opinion between Mrs W and the family court advisor about which of the children had said what during the family court advisor's interview with them, and that such differences of opinion were for the court to consider. However, there was an error in the family court advisor's amended report about which child had initiated the name change, and the family court advisor should have amended this when Mrs W brought it to her attention. This error should have been noticed and rectified as part of Cafcass's complaints procedure, so that Mrs W did not have to pursue matters as she did.

While we did not agree that the family court advisor had let Mrs W's children down, and some of her concerns had been for the court to consider, we accepted that the family court advisor's errors had led Mrs W to question her professionalism, and had caused her frustration and inconvenience.

Putting it right

Cafcass accepted our finding that there was an error in the family court advisor's amended report that should have been corrected. It apologised to Mrs W for this oversight and for not addressing this part of her complaint thoroughly enough as part of its own complaints procedure.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 784/March 2015

Student Loans Company gave wrong advice about travel grant

Miss T had the opportunity to study abroad as part of her degree course. Before accepting the offer to study abroad, she contacted the Student Loans Company (SLC), but it gave her incorrect advice about a travel grant.

What happened

Miss T called the SLC twice before she accepted an offer to study abroad. On both occasions she was led to believe she would be entitled to a travel grant. But she would not have automatically been entitled to the grant because she was not in receipt of income-assessed student finance.

After Miss T had accepted the offer, and paid for the course fees and travel insurance, she received an application form for the travel grant. On receipt of the form her mother called the SLC who gave her the correct information – that Miss T would not automatically be eligible for the travel grant. After receiving the correct information Miss T decided to carry on with her plans to study abroad.

Miss T complained to the SLC and was offered £200 in compensation. She was dissatisfied with this and came to us.

What we found

We did not uphold this complaint. The SLC did not give Miss T the correct information when she called on the first two occasions. As a result of that failure, Miss T lost the opportunity to make an informed decision about whether to accept the offer to study abroad. We did not find the financial losses claimed by Miss T were a direct result of the SLC giving her wrong information. Miss T decided to proceed with the study abroad, and incur more costs, even when she had the correct information. The £200 offered by the SLC was an adequate resolution to the complaint.

Organisation(s) we investigated

Student Loans Company Ltd (SLC)

Summary 785/March 2015

Rural business compensated for subsidy errors

The Rural Payments Agency's (RPA) errors merited compensation to Mr F for a lack of entitlements and subsidy payments.

What happened

Mr F applied to the RPA for a European Union farming subsidy called the Single Payment Scheme (SPS) in 2005. Farmers and other land-based businesses could claim the subsidy based on their entitlements, these are rights to claim the subsidy that were established in 2005. Farmers or other businesses could buy entitlements if they did not establish them in 2005.

Mr F submitted a valid claim, and then queried a discrepancy. RPA failed to process Mr F's 2005 claim or establish what his entitlement was and took so long to respond to Mr F's phone calls and letters that Mr F thought he was not eligible for SPS. After midsummer 2005, Mr F saw no point in contacting RPA.

In summer 2006 RPA wrote to Mr F. He telephoned RPA, who promised to call him back, but never did. RPA and Mr F were not in contact between summer 2006 and early autumn 2011. In 2011, Mr F found out from other people in his industry that they had received SPS payments so he contacted RPA about his own situation, making RPA aware of its 2005 errors.

RPA agreed to pay Mr F SPS for 2005 but because his entitlements had not been established in 2005, Mr F could not retrospectively submit claims for subsequent years. RPA told Mr F that to claim for 2012, he had to buy entitlements. RPA said that had Mr F submitted SPS claims from 2006 to 2011, it could have resolved its errors. Mr F did not see why he should buy entitlements when it was RPA's fault. Mr F's claim for 2012 was rejected because there were no entitlements. Mr F challenged RPA's decision not to pay in early autumn 2011 and appealed RPA's decision not to pay in summer 2012. In summer 2012, RPA told Mr F the nature of his challenge was more suited to its complaints procedure than the appeal process. RPA answered Mr F's complaint in winter 2012. It accepted it had got things wrong by failing to process Mr F's 2005 claim. It paid him SPS for 2005 and £100 compensation.

What we found

We partly upheld this complaint. RPA failed to process Mr F's application and establish his entitlements in 2005. It also failed to respond to Mr F's letters and phone calls. When Mr F contacted RPA in 2011, it acknowledged its 2005 failure but not the full impact of it, and did not make Mr F aware of the repercussions. RPA left it too long to tell Mr F that his challenge was suited to its complaints procedure rather than the appeal process.

However, Mr F also had some responsibility. While we accepted RPA's continual non-response in 2005 affected Mr F's decision making, he should have pursued RPA with more than one phone call when he received its 2006 letter. Mr F could and should have spoken to colleagues about SPS in 2006 to 2007. Had he done so, he would have discovered RPA's 2005 errors. Again in 2011, while we accepted RPA did not provide Mr F with information about the effects of its 2005 errors, he should have pursued RPA about claim values and the cost of entitlements. This would have allowed him to make an informed business decision about whether to purchase entitlements in 2012. He could then argue with RPA about reimbursing the cost of entitlements.

We nevertheless accepted that RPA's mistakes caused Mr F some injustice.

Putting it right

We recommended that: RPA apologise to Mr F for the failings we identified and the impact of these on him; reimburse Mr F the cost of buying entitlements on the open market; compensate Mr F for claim values between 2006 and 2011, subject to an inspection of his land to confirm precise eligibility; compensate Mr F 80% of the claim values between 2012 and 2014, again subject to confirmation of eligibility; and pay Mr F £250 for the frustration he experienced because of the length of time RPA took to answer his challenge and complaint.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 786/March 2015

No compensation for landowner following subsidy errors

Rural Payments Agency's (RPA) failure to automatically send a landowner a 2011 claim form and guidance was not the sole or direct cause of the landowner's failure to claim a subsidy in 2011.

What happened

Mr W bought land in spring 2011 and wanted to claim a European Union farming subsidy called the Single Payment Scheme (SPS) in 2011. A newcomer to SPS, Mr W told us he had no knowledge of the scheme and asked his agent to 'get the ball rolling'. The agent sent RPA both land transfer and customer registration forms on Mr W's behalf. Later in 2011, RPA told Mr W by letter that he was registered with it and he need do nothing more if his details were correct. Shortly after, RPA sent Mr W documents showing it had transferred his newly acquired land to his business. The letter contained RPA's contact details.

RPA was legally obliged to send claim forms to claimants, and claims had to be made by late spring each year. RPA said it did not send Mr W a claim form in 2011 because he missed the 'cutoff' date, which was in early spring 2011. RPA said it automatically sent a claim form to everybody registered with it on this date. Anyone who was not registered would not get a claim form. Mr W thought he would automatically be paid SPS for 2011 because RPA's letters said he did not have to do anything. Mr W did not contact RPA until late spring 2012, when RPA told him he would not get SPS for 2011 because he had not made a claim. Mr W appealed RPA's decision in summer 2012 but it was not until spring 2013 that RPA told him its complaints procedure was more appropriate.

Mr W's case was that RPA's failure to send him a 2011 claim form was the only reason he did not make a claim and get payment.

What we found

We partly upheld Mr W's complaint. RPA did not publish its cutoff date. If it wanted to maintain this, it had to ensure that the claimants who registered with it after the early spring cutoff date were not disadvantaged because of the date they registered. We concluded that as RPA is legally obliged to send claimants the claim form, that obligation is continuous irrespective of when a claimant registered with RPA. RPA's failure to tell Mr W that its complaints procedure was more appropriate for him until early spring 2012 delayed the outcome of his complaint.

However, Mr W made no effort to find out about SPS processes and procedures. He was unaware that he had to submit a claim or that there was a deadline. We found it would have been reasonable for Mr W to find out about the basic SPS processes/procedures or to contact RPA to find out how to claim. RPA's failure to send the claim form did not directly result in Mr W's failure to claim SPS in 2011.

Putting it right

RPA apologised to Mr W and paid him £250 compensation.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 787/March 2015

Border Force failed to carry out full enquiries when staff stopped a man at the UK border

Border Force failed to interview Mr D's partner when he was stopped at the UK border and it had unclear guidance about handcuffing detainees.

What happened

Mr D arrived in the UK from Spain and was stopped at the UK border. Border Force made some enquiries of the NHS and believed he was accessing NHS treatment to which he was not entitled. Border Force refused Mr D entry to the UK. It decided to detain him overnight and he was escorted to an immigration removal centre in handcuffs.

What we found

We partly upheld this case. When Border Force was making enquiries about whether Mr D was accessing NHS treatment, it should have interviewed Mr D's partner. However, we did not find that Mr D's partner would have been able to give Border Force significantly more information and so we found no injustice arising from this failure.

Border Force's guidance on handcuffing passengers when they are being escorted was unclear at the time of these events. However, the decision to handcuff Mr D was reasonable. We also noted that Border Force had recently changed the guidance to clarify when handcuffs should be used.

Putting it right

We did not find that Border Force's actions caused Mr D any injustice. We made no recommendations for Border Force.

Organisation(s) we investigated

Border Force

Summary 788/March 2015

Computer error caused a decade of confusion

A computer error made by the Rural Payments Agency (RPA) in 2005 caused confusion and upset until 2015 for a retired farmer and his wife.

What happened

A computer error removed a fundamental piece of information from the calculations for Mr and Mrs J's 2005 claim for a European Union farming subsidy called the Single Payment Scheme (SPS). The RPA's computer systems repeated its mistake for SPS 2006. It repeated it again for SPS 2007. In 2008 the RPA realised it had paid Mr and Mrs J almost £3,000 too much. It started to recover this, although Mr and Mrs J said it should not. They made a partly successful appeal against RPA's decision but RPA continued to seek repayment of some of the money.

What we found

RPA acknowledged its computer errors, but failed to give Mr and Mrs J a fair response to their complaint until 2013. In particular, it mishandled its own appeal process. RPA delayed making a formal decision about whether, legally, the overpayment was recoverable. The decision, when it made it, failed to take account of all the relevant considerations. It lacked an adequate approach to debt recovery in cases like this.

Putting it right

RPA needed to give Mr and Mrs J a proper decision, in line with our findings, about whether or not to recover the overpayment. It also needed to take account of the effect of the incorrect information caused by the computer error. Accurate information would have let Mr and Mrs J use their SPS assets properly and plan ahead in order to sustain their SPS claim after 2009.

RPA agreed to apologise to Mr and Mrs J; review its decision about recovering the overpayment; make Mr and Mrs J an apology payment of £2,000 to recognise the lost opportunity to make properly informed decisions about how to use their SPS assets and the effect of poor complaint handling; and to produce guidance for claimants and staff on the recovery of overpayments that, fairly, set out the responsibilities of RPA and of claimants.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 789/March 2015

When farm subsidies become a lottery

A part-time farmer learnt the hard way that government departments make mistakes – even when it comes to paying out thousands of pounds too much in farm subsidies.

What happened

Mr H claimed European Union farming subsidies under the Single Payment Scheme (SPS) run by the Rural Payments Agency (RPA). Its electronic data errors meant it paid him almost £15,000 for 2005 and 2006 – over 10 times what it should have paid him. Mr H accepted the figures RPA sent him and treated the payments as correct.

RPA discovered its mistake in 2007 and told Mr H about this in 2008. It started taking the money out of his annual subsidy payments. He complained, insisting the payments had been correct.

In 2010, data errors led RPA to decide it had underpaid Mr H. It made him a payment of over £20,000 in subsidy. But this was another mistake. Mr H, now over 70 years old, is still repaying the money to RPA.

What we found

We partly upheld this complaint. RPA's data errors led to it overpaying the subsidy. It took too long to identify the first overpayments and the correct payment position. It sent incorrect information to Mr H about his subsidy claim, based on its incorrect data. It mishandled the decisions to recover the overpayments. It lacked a debt recovery approach that adequately balanced its conflicting duties to the European Commission and to its customers. Its approach to remedy when it considered Mr H's complaint was wrong.

Without RPA's mistakes, there would have been no overpayments. Mr H would have had accurate information instead of a series of apparent pay-outs that were in fact unsolicited loans. He would have had properly made decisions about his queries that gave him the information he needed to challenge them. He would have avoided, at an age when he wanted to retire, the prolonged stress and trouble of dealing with and seeking to challenge RPA's decisions. But when Mr H received the 2010 overpayment, he should have been more suspicious that RPA had made another mistake. That would have lessened the trouble he went through.

Putting it right

RPA apologised to Mr H and made him a consolatory payment of £750 for the inconvenience and frustration caused. It reviewed its decision about whether or not the SPS 2005 and SPS 2006 overpayments were recoverable, taking note of our finding about the flaws in its earlier decision. It concluded that it was correct to recover the overpayments. RPA also agreed to produce guidance for claimants and staff on the recovery of overpayments that, fairly, sets out the responsibilities of RPA and of claimants.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 790/March 2015

Wrong advice had repercussions for farmer

The Rural Payments Agency (RPA) mistakenly told a small farmer that he could claim and receive over £4,000 in subsidy. He paid a full price for his pay-out.

What happened

Mr J asked the RPA whether he could claim farming subsidy. He had missed some claim years and thought he might have lost his eligibility. The RPA told him that he could claim under the Single Payment Scheme (SPS) for 2010 and again for 2011. It was wrong. In 2012 it fixed its computer error and asked him to repay £4,350. The RPA apologised for giving Mr J incorrect information and offered him £100 by way of apology. But it did not pay him the money and offset it against the debt. Mr J told RPA that he could not afford to repay the debt as quickly as it wanted and that doing so would cause him hardship and force him to sell his animals. When it used government lawyers to threaten him with legal action, he used a bank loan to repay the subsidy.

What we found

RPA put an incorrect useby date for Mr J's SPS entitlements for his SPS 2010 and 2011 claim years. It did not tell him about this error for two years and paid him £4,250 he should not have received. It wrongly decided that he should have realised it had overpaid him. It failed to offer him a fair and proportionate repayment period for the debt that it should have written off. It then mishandled his complaint about this.

Mr J would not have claimed subsidy incorrectly without RPA's written and spoken information, which was based on inaccurate data. His success in being able to borrow money over a repayment period that he can afford means he has not had to sell his animals. But RPA's mistakes denied him the accurate information he needed to plan his finances; caused him anxiety about how he could repay the money; caused him to fear a visit from court-appointed bailiffs after the government lawyers took a hand and left him in debt, just at the point when he had expected to become debt-free.

Putting it right

RPA apologised to Mr J; and reviewed its decision about recovering the overpayment, taking account of what we had said about the flaws in its earlier decision. It paid him £1,000 by way of apology; and agreed to produce guidance on the recovery of overpayments that, fairly, sets out the responsibilities of the RPA and of claimants.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 791/March 2015

Independent Case Examiner's investigation failed to address two issues

An investigation by the Independent Case Examiner (ICE) failed to consider one part of Mr D's complaint and did not explain why it would not consider another part of the complaint.

What happened

Mr D complained to ICE, the second tier of Jobcentre Plus's complaints procedure, about Jobcentre Plus's actions. One of Mr D's complaints was that Jobcentre Plus had put restrictions on his benefits. ICE failed to explain to Mr D that he had raised this complaint too late, outside the time frame in which ICE can look at a complaint. Mr D also complained that Jobcentre Plus had not acknowledged his education and work experience before 2005. ICE agreed to investigate that complaint but then failed to include it in its final investigation report.

What we found

We partly upheld this complaint. ICE's investigation of Mr D's complaint was largely reasonable. However, there were two failures. First, ICE failed to explain that Mr D's complaint about the restrictions on his benefits was out of time and it would not consider it. Secondly, ICE failed to investigate Mr D's complaint that Jobcentre Plus had not acknowledged his past education and employment experience.

ICE's failure to consider these issues meant Mr D was left without explanations and that he had to complain to us to get the explanations. We found this would have caused Mr D some frustration and inconvenience.

Putting it right

ICE apologised to Mr D.

Organisation(s) we investigated

Independent Case Examiner (ICE)

Summary 792/March 2015

Small claims case struck out at court after man followed instructions

Mr R complained that HM Courts & Tribunals Service (HMCTS) did not give him enough information on court form N157, that the court did not send him guidance and that the court did not give a judge a letter that said Mr R was not going to be at the hearing.

What happened

Mr R said he followed the instructions on the form HMCTS had sent him but the judge struck out his case because he did not follow all the rules he had to. HMCTS did not send Mr R a guidance leaflet that might have helped him understand what to do before his hearing. Mr R said he had a strong case to win £500 but lost the chance and had to pay £90 in court fees. Mr R said he suffered stress, and he wanted £600 in compensation.

What we found

We partly upheld the complaint. Nothing suggested that the court did not put the letter on file for the judge to see. But HMCTS should have given Mr R clear, complete and accurate information about what to do, and it should have sent Mr R its guidance or referred him to it. He suffered frustration and stress, and was left having to make the difficult decision of whether or not to apply to have the judgment (that the case be struck out) cancelled. Mr R should not have had to escalate his complaint to us.

Putting it right

HMCTS apologised to Mr R and paid him £100 in compensation. It also reviewed the literature it gives litigants before a hearing, in particular the court form N157, to make sure it gives clear, complete and accurate information in line with *The Civil Procedure Rules*.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 793/March 2015

UKVI failed to take action to implement a successful appeal and consider a complaint

Mr L was unhappy about how UK Visas and Immigration (UKVI) had handled his application to stay in the UK. Although UKVI rejected his appeal, it was eventually allowed. Mr L felt that UKVI's actions meant he had lost some earnings and he was also concerned about its complaint handling.

What happened

Mr L complained that UKVI unfairly refused his application for leave to remain in early 2011. Mr L subsequently appealed the decision, at a First-tier Tribunal, an independent tribunal that deals with appeals against immigration decisions, and again at the Upper Tribunal, which looks at decisions made by the First-tier Tribunal. The Upper Tribunal overturned the First-tier Tribunal's decision at the end of 2011. Some four months later, in spring 2012, UKVI issued Mr L's leave to remain.

Mr L complained to UKVI in summer 2012. He was unhappy that UKVI did not apply the Upper Tribunal's decision until spring 2012. He said he incurred extra costs because of the delay and the initial unfair refusal of his application. Mr L was concerned that the original decision to refuse his visa had contributed to a loss of earnings as he could not take all the work he was offered.

Mr L also complained that he was unable to travel during this time, and said he had been unable to visit his mother overseas while she was recovering from an operation, which had caused him distress. Mr L's MP contacted UKVI in spring 2013. In early summer 2013, UKVI offered Mr L £50 in compensation for poor communication. Mr L brought his complaint to us.

What we found

We partly upheld this complaint. UKVI failed to apply a policy that would have allowed it to be flexible on the evidence it asked for when it first assessed Mr L's application for leave to remain. However, on the balance of probabilities, if UKVI had requested the appropriate information, there is no evidence that Mr L or his representative had sufficiently understood the requirements to be able to meet the request, so Mr L's application would probably still have had to go through the appeal process.

There was also failure to take action to issue Mr L's visa after the Upper Tribunal's decision in late 2011; failure to take action for six months before beginning to consider Mr L's claim for compensation and four months' processing time; failure to communicate this process to Mr L; the failure to offer an appropriate remedy when UKVI first accepted responsibility for the delay in issuing Mr L's visa after the Upper Tribunal's decision. Had these errors not occurred, Mr L would probably have been issued a visa in early 2012 instead of spring 2012. This caused Mr L emotional distress, and considerable frustration, and prevented him from travelling to visit his mother when she was ill.

Putting it right

To remedy the injustice UKVI wrote to Mr L to apologise for the mistakes we identified. It also paid him £350 to compensate for the worry, anguish and distress caused by his inability to travel to see his mother, and also to recognise the inconvenience, additional time, trouble and disempowerment caused by its handling of Mr L's complaint, and its failure to acknowledge, or act on, communications from Mr L's representatives chasing his leave to remain.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 794/March 2015

Child Support Agency failures meant man accrued maintenance arrears

The Child Support Agency (CSA) told Mr N that his maintenance liability was lower than it should have been, leading him to accrue arrears. The Independent Case Examiner (ICE) failed to take into account the non-financial impact of this error.

What happened

An error at the CSA meant that Mr N was told his maintenance liability was lower than it should have been. For five years Mr N paid the maintenance the CSA had told him he owed and a payment towards the existing maintenance arrears. At the end of five years, the CSA told Mr N that the amount he owed in arrears had increased because the figure it had told him he owed had been too low.

Mr N complained to ICE, which reviews complaints about the CSA. It said that Mr N's complaint about the CSA was justified but it said this error had not caused Mr N a financial loss.

What we found

We partly upheld this complaint. The CSA's failure to give Mr N an accurate figure for his maintenance liability meant that he spent five years believing he was meeting his maintenance liability and paying off previous arrears when he was doing neither. When Mr N learnt that the arrears had actually increased, this would have caused him surprise and shock. The error meant that Mr N lost the ability to make well informed, fact-based financial decisions about how much he could afford to pay towards the arrears each month.

ICE was correct to say the error had not caused Mr N a financial loss but there was no evidence it had considered the non-financial impact on him.

Putting it right

CSA apologised to Mr N and paid him £500 in recognition of the shock, stress and loss of opportunity he experienced as a result of its error.

ICE also apologised to Mr N.

Organisation(s) we investigated

Child Support Agency (CSA)

Independent Case Examiner (ICE)

Summary 795/March 2015

HMCTS's poor communication with man in his nineties about bailiff visits

Mr A complained that HM Courts & Tribunals Service (HMCTS) sent bailiffs to the wrong address under the terms of a warrant to recover money he was owed. Mr A complained about how HMCTS dealt with his complaint. He said the court was difficult to contact and it did not update him properly about what the bailiffs were doing to get his money back.

What happened

Mr A had applied to court for bailiffs to carry out a warrant. The bailiffs visited the correct property but no one was there so they could not get Mr A's money back. HMCTS and the bailiffs did not give Mr A proper updates so he did not know what was happening or why the bailiffs had not managed to get his money back. The court told him he had written the wrong address on the application but it did not explain why it reached this conclusion. He asked to see his application but HMCTS had lost it. It repeatedly told Mr A that it would send it to him, but never did. Following his complaint, HMCTS offered Mr A £150 as compensation. Mr A did not think this was enough. He wanted HMCTS to pay him the value of the debt he was owed but which the bailiffs did not recover.

What we found

We partly upheld this complaint. The bailiffs' actions were reasonable: they tried to execute the warrant correctly and in line with the requirements. However, HMCTS should not have lost Mr A's warrant application. Its communication and complaint handling was extremely poor. Its mistakes caused Mr A frustration, confusion, inconvenience and a loss of faith in the system.

Putting it right

HMCTS apologised to Mr A and paid him £250. We did not ask HMCTS to pay Mr A the value of the debt owed to him because he had a charging order in place to recover that amount and the bailiffs' actions were reasonable.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 796/March 2015

Cafcass failed to vary a court order

Mr B complained that Cafcass failed to follow a court order to allow him to see his children. He said that its response to his concerns was inadequate because it just endorsed its own actions. Mr B said that Cafcass was partly responsible for his loss of contact with his children.

What happened

A court ordered that a Cafcass officer (the officer) should meet Mr B's children and supervise one session of contact between them and Mr B. However, before that meeting took place, the officer became aware that it was likely the children had witnessed Mr B assaulting their mother. The officer discussed the case with her manager and they decided that the officer would see the children to establish their wishes and feelings before she arranged the supervised contact session. The contact session did not take place.

Less than two months later, the court ordered that supervised, weekly contact should take place between Mr B and his children. Contact started but broke down soon after.

Mr B complained to Cafcass. In its response to the complaint, Cafcass reported the views of the judge, who said that she did not think the officer had acted unprofessionally.

What we found

We partly upheld this complaint. It was the officer's professional judgment that she should not supervise a contact session between Mr B and his children. This was an opinion she was entitled to hold and one that could have been challenged in court. The officer tried to clarify the court order with the court and the judge. However, when it became clear that she was unable to do this quickly, the officer should have recognised that the correct procedure was to apply to the court to vary the court order. The officer did not do so; she did not get this right.

While Cafcass accurately reported some of the information from the judge in its response to Mr B's complaint, it did not disclose all of the judge's comments – some of which were critical of Cafcass. Cafcass did not acknowledge that the officer should have sought to vary the court order, as the judge had stated. We did not consider that Cafcass was open and accountable.

However, we did not believe that the officer's decision not to arrange one contact session between Mr B and his children resulted in contact breaking down. The court subsequently ordered contact and some contact took place between the children and Mr B. However, this contact was not without its difficulties. We noted that Cafcass's recommendation in a report to the court was that further contact should take place, and the court ordered such contact. We also noted that the officer tried to facilitate contact between Mr B and his children by giving them reassurance and support both in person and by email.

From the evidence we saw, it seemed that contact broke down because the children no longer wanted to see Mr B. It appeared the children's views persisted, despite the court suggesting mediation and psychotherapy. There was no evidence to suggest that the children's views were formed as a result of missing one supervised contact session with Mr B.

We concluded that, while the officer should have applied to vary the court order, we could not say what the outcome would have been had she done so. We could not reasonably say that her failure to vary the court order led to the breakdown of contact between Mr B and his children.

Putting it right

We recommended that Cafcass apologise to Mr B for the officer's failure to follow the correct process by applying to the court to vary the court order and for its failure to be open and transparent in its complaint response to him. But Mr B did not want Cafcass's apology so we did not follow up with this.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

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Summary 797/March 2015

HMCTS lost court bundle before hearing

HM Courts & Tribunals Service (HMCTS) lost court papers in Mr M's small claims case and failed to give him an adequate explanation.

What happened

Mr M took his landlord to the small claims court but HMCTS lost some of the court papers so the judge could not read them before the hearing. The judge went ahead with the hearing, and listened to verbal statements. At the end of the two-hour hearing, he adjourned and ordered a further four-hour hearing to complete the case. But the judge did not put his papers in the file and HMCTS spent weeks trying to contact him for his notes and court order. HMCTS also had difficulty contacting the judge for a date for the second hearing so another judge agreed to hear it. At the second hearing, five months after the first hearing, the judge found partly in favour of Mr M and awarded him £750 plus costs. Mr M complained to HMCTS about the delay and said that he had experienced very poor customer service. HMCTS apologised and offered him £75.

What we found

We partly upheld Mr M's complaint. HMCTS should not have lost the court bundle. We understood Mr M's annoyance and frustration at the delay in rescheduling his court date but a significant part of the delay was caused by a judicial error and practical difficulties arising from that error. However, HMCTS's communication with Mr M was poor and not customer-focused. We also found failings in its response to his complaint.

Mr M did not suffer any injustice through HMCTS misplacing the court bundle. Even if the judge had had the bundles, he would still have adjourned the case because he considered that it needed more time. As we found no fault in how HMCTS dealt with the case after the hearing, we could not say that Mr M suffered any injustice. However, HMCTS's poor communication increased Mr M's anxiety and stress and that was an injustice.

Putting it right

HMCTS apologised and offered Mr M a consolatory payment of £75.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 798/March 2015

Cafcass apologised for poor complaint handling

When Mr and Mrs G complained to the Children and Family Court Advisory and Support Service (Cafcass) about the actions of their son's court-appointed guardian, they encountered an overly rigid complaint procedure because Cafcass refused to look at evidence that it had previously asked for.

What happened

Mr and Mrs G complained to Cafcass that the guardian had changed her mind in court and had commented on matters that she had said she was not going to be involved in. As a result, Mr and Mrs G felt that the guardian had changed the outcome of the court case.

When Mr and Mrs G complained to Cafcass, they wished to submit evidence from their solicitor to support their account of what the guardian had said. Unfortunately, the solicitor was unwell at that time. Cafcass responded to the complaint and asked Mr and Mrs G to send in the solicitor's evidence when it became available.

A few months later, Mr and Mrs G sent the solicitor's evidence to Cafcass. However, Cafcass replied that its one-step complaint procedure was completed and the case was closed. It took several emails before Cafcass agreed to look at the evidence, even though it had requested it. Once Cafcass had looked at the evidence, it sent a further closing letter to Mr and Mrs G and did not explain why it did not consider that the evidence changed its decision.

What we found

We partly upheld this complaint. We were unable to make findings on the guardian's actions because the evidence was conflicting and we could not confirm what the guardian had said. Any view expressed by the guardian would be a matter for her professional judgment and therefore would be most appropriately addressed in court.

Cafcass's complaint handling was poor. Cafcass was overly rigid in applying its one-step complaint procedure. It was frustrating that it initially refused Mr and Mrs G's evidence after it had asked them for it. It was also very unhelpful that Cafcass did not offer any further explanation once it had considered the evidence.

Putting it right

Cafcass apologised to Mr and Mrs G for its handling of their complaint.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 799/March 2015

Cafcass misspelt name in report

Miss B complained about the Children and Family Court Advisory and Support Service's (Cafcass's) care and efficiency and the amount of information in its reports.

What happened

Cafcass misspelt Miss B's daughter's name in a letter to the court. It then sent the court an amended letter. Cafcass did not pick up this error as part of its complaint handling.

What we found

We partly upheld this complaint. Cafcass had misspelt Miss B's daughter's name in a letter to the court but quickly amended this and sent the amended letter to the court. When Miss B complained about this issue to Cafcass, it failed to acknowledge that it had originally made a mistake.

Miss B also complained about the professional judgment of a Cafcass officer. We took the view that these matters would have been best challenged in court where the officer could be called to give evidence and be cross-examined.

Putting it right

Cafcass acknowledged its error and accepted that it should have spoken to the original officer to find out what had happened. It apologised to Miss B for its poor complaint handling.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 800/March 2015

An administrative error by HMCTS when it listed a final hearing meant wasted costs for solicitors

A final hearing that was due to take place in late spring 2013 had to be adjourned until early autumn 2013 because of an administrative error by HM Courts & Tribunals Service (HMCTS).

What happened

A final hearing was listed to take place in spring 2013. The solicitors and their client attended court but only to find that an administrative error by HMCTS meant the hearing had to be adjourned. The solicitors complained to HMCTS, who accepted the error, and offered the solicitors £2,000 for wasted costs. The solicitors wanted £2,750 to fully reflect all the extra work they had to do as a result of HMCTS's error. However, correspondence continued between the solicitors and HMCTS about the appropriate level of financial redress. The solicitors' referred it to us.

What we found

The £2,000 offered by HMCTS was not an adequate remedy to the solicitors' complaint. Based on the cost schedule provided by the solicitors to show what their losses were as a result of HMCTS's error, we worked out the exact direct financial loss to be just over £2,600. We put that to HMCTS, who agreed to put matters right.

Putting it right

HMCTS increased its offer to the solicitors of financial redress from £2,000 to over £2,600.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 801/March 2015

Complaint that Cafcass's involvement with hearing in the family courts negatively affected proceedings

Miss S complained to us about inaccuracies in a report that the Children and Family Court Advisory and Support Service (Cafcass) produced in a family court hearing.

What happened

Miss S was opposed to her ex-partner's application to obtain a 50/50 shared residence order for their child. She felt that regular contact would be more appropriate. The court asked Cafcass to produce a report to help it decide on the application. When Miss S received the report, she was distressed to find that Cafcass had recommended that her ex-partner should be given shared residence. Miss S also noted that the report contained a factually inaccurate statement, and she told Cafcass about this. Cafcass realised the error and wrote to the court to correct this; however, Cafcass then made another inaccurate statement to the court. Miss S went to the final hearing with her legal representative to challenge Cafcass's recommendation.

During the court hearing, the Cafcass officer realised that they had overlooked a vital piece of information at the time they wrote their report, and they revised their recommendation. The court awarded Miss S sole residency of the child and gave her ex-partner regular contact. Miss S then complained to Cafcass and said there had been a lack of professionalism in its handling of the case.

Miss S also complained that Cafcass had caused her unnecessary legal costs because of the errors in the report and she asked Cafcass to pay her compensation.

Cafcass apologised to Miss S for its mistakes, but said the court had not awarded any costs against it. Cafcass declined to pay compensation to Miss S and she asked her MP to refer the complaint to us.

What we found

We partly upheld this complaint. There was a failing when Cafcass produced its report for the court. This caused Miss S unnecessary distress because the report suggested there was a strong possibility that her ex-partner would be given shared residency. Miss S would not have known until the date of the hearing that Cafcass had overlooked an important piece of information and that its recommendation was wrong. We decided that Cafcass should pay Miss S £150 compensation for the distress it had caused.

However, in relation to the legal costs, we decided that we would be speculating if we said that Miss S could have avoided those legal fees, in what was a contested dispute between her and her ex-partner.

Putting it right

Cafcass paid £150 to Miss S.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 802/March 2015

Poor complaint handling after an execution of a search warrant

The Home Office left insufficient information for Miss D about a raid on her home while she was away, and handled her complaint about the matter inadequately.

What happened

The Home Office entered Miss D's house with a search warrant in late spring 2011 while she was away. Her two lodgers were at home and one of them was arrested for immigration offences. The door to Miss D's bedroom was locked and the Home Office broke it down to gain entry. On her return home in summer 2011, Miss D had trouble finding out who she should contact about compensation for the damage caused. She sent her claim to the Home Office in late summer 2011 but despite chasing matters by telephone and visiting offices, she did not receive a response until autumn 2012 when the Home Office told her that she was not due any compensation because staff had had a search warrant.

Miss D sought advice from various organisations including her MP, who contacted the Home Office about her case. In winter 2013 the Home Office wrote to Miss D to say that it had reviewed the case and had decided that no compensation was due.

What we found

We partly upheld this complaint. Because the Home Office had entered Miss D's house with a valid search warrant, no compensation was due for the damage caused.

However, the Home Office had left very poor information for Miss D about who to contact about the raid. She was put to considerable trouble and inconvenience in trying to find out if she could claim compensation and who to send her claim to. The Home Office then handled her case very poorly: it misled her into believing that she would be compensated and took far too long to respond to her claim. All this caused Miss D inconvenience and stress, and aggravated her health problems.

Putting it right

The Home Office wrote to Miss D to apologise for its poor handling of her case and paid her £500 for the inconvenience and distress caused.

Organisation(s) we investigated

Home Office

Summary 803/March 2015

HM Passport Office mixed up passport photographs

HM Passport Office (HMPO) put the wrong photographs in two passports and then failed to give a full apology and explanation.

What happened

Mr B's daughter was invited by a friend to go on a holiday abroad. Mr B applied for the renewal of two of his daughters' passports at the same time – about a month before the proposed holiday. But when the passports came back, the girls' photographs were mixed up. HMPO told us that if it makes a mistake, it tells the customer to send in a new application and it would aim to process this within a week. Mr B said that when he phoned HMPO's passport advice line he was not given this information by the advice line operator. There were no records, so it was not clear what advice he was given. He sent back the passports with a covering letter and new photographs.

A week later HMPO told him he needed to make a new application but that it would try to make sure that his daughter got the new passport in time. Mr B initially refused to submit a new application and did not buy a flight ticket for his daughter because he could not be sure the passport would arrive in time. Mr B later filled in new applications and received the new passports but they did not arrive in time for his daughter's holiday. He complained to HMPO about its mistake and asked for a full explanation.

What we found

We partly upheld Mr B's complaint. HMPO was at fault for mixing up Mr B's daughters' photographs. However, because there was no evidence of what advice was given when Mr B called the advice line, we could not say that he was deprived the chance to make an expedited application that would have allowed his daughter to go on holiday. HMPO did not provide a full apology and explanations of what had gone wrong, or respond to his complaints.

Putting it right

Following our investigation, HMPO apologised and paid Mr B £50 compensation to reflect the annoyance and inconvenience he experienced.

Organisation(s) we investigated

HM Passport Office (HMPO)

Summary 804/March 2015

Cafcass inappropriately disclosed information at a hearing in the family courts

Ms G complained to us about the way the Children and Family Court Advisory and Support Service (Cafcass) had gathered safeguarding information, and how it presented this information at a family court hearing.

What happened

Ms G discovered that her ex-partner had made an application to the family courts for a contact order with her child. Ms G had safeguarding concerns about her ex-partner and did not want him to be given direct contact. Cafcass produced an introductory report for the court, which summarised the allegations Ms G had made, as well as some counter-allegations made by Ms G's ex-partner.

The court subsequently directed Cafcass to carry out work to begin the process of reinstating contact between Ms G's child and the father. Cafcass had a number of conversations with the parties in the months following the court's direction. Ms G complained to Cafcass that it had not presented all of the allegations she had made about her ex-partner. Ms G said Cafcass had not properly looked into her ex-partner's behaviour.

Ms G was unhappy that she was being instructed to make her child available for contact with her ex-partner. She also complained that Cafcass had inappropriately disclosed information about her to her ex-partner. Cafcass told Ms G that if she wanted to challenge the professional judgment of one of its officers, she must do this in court. Cafcass told Ms G that it did not consider it had inappropriately disclosed information about her because she had disclosed the information herself in open court.Ms G wrote to Cafcass to disagree with its findings, and explained that it was wrong to say she had disclosed the information in open court. Cafcass told Ms G that she had reached the end of its complaints process and she should therefore refer her complaint to us.

What we found

We partly upheld this complaint. We agreed with Cafcass that the concerns Ms G had about her ex-partner and his contact with her child were matters that had to be considered by the court. We told Ms G that it was only the court that could make a binding decision. Cafcass had reasonably brought to the court's attention the allegations and counter-allegations made by the parties. When we proposed investigating the complaint, Cafcass realised that its initial response had contained an inaccuracy about what Ms G had said in open court. Cafcass acknowledged this mistake to us, but we considered that it should have apologised to Ms G for the mistake. We noted that Ms G had already told Cafcass about the error, so it had previously been given an opportunity to correct matters before she came to us.

Putting it right

Cafcass apologised to Ms G.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 805/March 2015

UKVI did not meet its statutory deadline for dealing with residency application

UK Visas and Immigration (UKVI) took nine months to consider the application for permanent residence from an EU citizen's wife.

What happened

Ms A was married to a European citizen who was allowed, under European Union law, to work and live in the UK. Ms A applied for permanent residency, because she was entitled to do, and by EU law her application should have been decided within six months. But UKVI did not look at it for over six months. It then rejected the application because Ms A had not given it all the supporting papers it asked for. UKVI told Ms A she might have to leave the UK. Ms A appealed the decision and was told that she had the right to remain in the UK during the appeals process. However, a private company, contracted by the UKVI to track down illegal migrants, telephoned and wrote to her to tell her she should make arrangements to leave the UK. At the tribunal hearing, UKVI said it now had all the documentation and would look afresh at her application. It then granted her permanent residency in the UK. Ms A complained about what had happened and was dissatisfied with UKVI's response.

What we found

We partly upheld this complaint. UKVI should have looked at Ms A's application within six months. However, it had been right to reject it because Ms A had not sent all the supporting documentation. Once Ms A had appealed, she had a right to stay in the UK during the appeals process but UKVI was not notified of Ms A's appeal for over a month. As a result, the private company was not aware that Ms A had put in an appeal when it contacted her, so there was no fault there. However, UKVI could have responded more fully to her complaint.

Putting it right

UKVI apologised to Ms A for not deciding her application within six months and for responding inadequately to her complaint.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 806/March 2015

Wrong decision on settlement application

Mr R complained that UK Visas and Immigration (UKVI) mishandled his settlement application and failed to compensate him properly.

What happened

Mr R applied for settlement in the UK in early 2013. In summer 2013 his father died overseas. In autumn 2013 UKVI refused Mr R's application on the basis that he had not been lawfully in the UK for the 10 years necessary to gain indefinite leave to remain. Mr R appealed. In late 2013 the presenting officer's unit reviewed Mr R's case. It decided that the decision was factually incorrect and that UKVI should withdraw from the appeal and reconsider the decision. In spring 2014 UKVI reconsidered the decision and granted Mr R settlement. Mr R complained about the service he had received and asked UKVI to compensate him for having to appeal and incur additional legal costs and for the impact on him for missing his father's funeral overseas, and his inability to travel to see his family for such a long time. UKVI agreed to reimburse Mr R £144 for his appeal hearing fee and pay him £250 consolatory payment. Mr R was dissatisfied with this amount because he had hoped to have his full legal fees paid and a higher amount of compensation to recognise the impact of not being able to attend his father's funeral.

What we found

We partly upheld this complaint. Although UKVI did not decide Mr R's application within the six-month timescale, the two-month delay was not unreasonable. It had a backlog of work and Mr R had not asked it to expedite his application to see his father or attend his funeral. UKVI made a mistake when it decided Mr R's application, and his application should have been granted in autumn 2013. Mr R complained about the matter three times in 2014 before UKVI took any action. While it decided Mr R's claim for compensation, it failed to provide a response that addressed his concerns.

Putting it right

UKVI wrote to Mr R apologising for the errors it had made in dealing with his application and his complaint to it. But we were satisfied that its offer to reimburse Mr R's appeal fee and the consolatory payment offered was appropriate in the circumstances. We were not persuaded that Mr R missed his father's funeral because of UKVI's mishandling of his application or that UKVI should be responsible for Mr R's legal fees.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 807/March 2015

Cafcass's error led to cancellation of hearing

The Children and Family Court Advisory and Support Service (Cafcass) failed to notify relevant officer of a court hearing they were due to attend, which led to it being cancelled and the complainant incurred legal costs.

What happened

Mr F was in dispute with his ex-partner over the contact he could have with the couple's child. There was a series of court hearings designed to resolve this dispute and the court asked Cafcass to be involved.

Mr F complained that two court hearings were cancelled because Cafcass failed to attend. He also complained that a third hearing had to be rearranged because the judge was unhappy with the quality of Cafcass's work. Mr F asked Cafcass to compensate him for the legal costs he had paid in relation to these hearings. Cafcass refused this request because it did not feel it had made any errors.

What we found

We partly upheld Mr F's complaint. One of the hearings had been cancelled as a direct result of Cafcass's failure to attend. However, the second hearing had not, in fact, been cancelled; it had still gone ahead in Cafcass's absence. There was no evidence that the outcome of that hearing would have been different if Cafcass had been there or not.

There was no evidence that the third hearing had been rearranged because the judge was unhappy about Cafcass's work. It was required because fresh information had emerged in court.

Putting it right

Cafcass apologised to Mr F for its failure to properly consider his request for compensation. It also offered Mr F £350 as compensation in relation to the cancelled hearing.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 808/March 2015

Coal Authority failed to deal with mine shaft query

The Coal Authority was not customer focused when it responded to a complaint about the location of a mine shaft.

What happened

The Coal Authority told Mr J there was a mine shaft located on his property. Mr J told the Coal Authority it had got the position of the mine shaft wrong. The Coal Authority did not consider Mr J's information and took no action. Mr J tried to sell his house, and the Coal Authority provided the prospective buyer with a mining search report that indicated that there was a mine shaft on the property. The prospective buyer pulled out of the purchase. Mr J complained again, more than once, to the Coal Authority saying it had got the position of the mine shaft wrong. The Coal Authority looked at Mr J's information and decided the mine shaft was not located on Mr J's property. But the Coal Authority did not fully look into Mr J's complaint because it focused on its legal liabilities. The Coal Authority said that while it was now satisfied that the mine shaft was not located on Mr J's property, it was not liable for any additional costs Mr J had incurred.

What we found

We partly upheld this complaint. When Mr J challenged the location of the mine shaft the Coal Authority should have looked into it. It should also have flagged the data so it was not released in mining reports until the matter was resolved. The Coal Authority did neither of these things. That was maladministration.

The Coal Authority was not customer focused when it responded to Mr J's complaint. It did not identify the mistake it had made or consider the impact this had on Mr J.

We did not find those mistakes could be linked to what happened to Mr J's property sale. Mr J put his property on the market without receiving any indication from the Coal Authority that the recorded position of the mine shaft had been changed. We found the Coal Authority had caused Mr J frustration and inconvenience by not handling his complaint properly.

Putting it right

The Coal Authority apologised for failing to act on Mr J's original concerns and for failing to handle his subsequent complaint properly. It paid Mr J £150 in recognition of the frustration and inconvenience caused.

It also reminded relevant staff of the circumstances under which they should review data about a mine shaft location.

Organisation(s) we investigated

The Coal Authority

Summary 809/March 2015

Error in arranging a hearing did not lead to the complainant losing his court case

An administrative error by HM Courts & Tribunals Service (HMCTS) led to a court hearing being cancelled.

What happened

Mr W applied to a court to be given control over his wife's financial and property affairs. His application was due to be heard at a court hearing. However, because of an administrative error, the hearing did not go ahead.

The court then received an alternative application from another family member requesting control over Mr W's wife's affairs. After many months, during which the matter was transferred to another court, another court hearing was held. The court decided in favour of the family member rather than Mr W.

Mr W complained that, if the original hearing had gone ahead as planned, his application would have been the only one in existence and would therefore have been successful. He also complained, on many occasions, about the length of time it took to process the application.

HMCTS accepted it had made an error in relation to the original hearing. However, it did not accept that this had led to Mr W's application being unsuccessful. It said a judge had made the decision on the application and it had no power to overrule that decision.

HMCTS acknowledged that it had not handled Mr W's complaint as well as it should have. In particular, it should have responded to his concerns earlier than it did. It offered to pay Mr W £100 in recognition of its error.

What we found

We did not uphold this complaint. Although HMCTS had made errors in its handling of this case, it had made reasonable attempts to put matters right for Mr W.

We agreed with HMCTS that its original error had not led to Mr W's application being unsuccessful. We noted that although the family member had not yet made their own application by the time of the original hearing, they, and others, had raised objections to Mr W's application. In light of these objections, we could not have been certain what the outcome of the original hearing would have been, if it had gone ahead. We also accepted that the final decision on the application had rested with a judge, not HMCTS.

HMCTS should have responded more quickly to the concerns Mr W raised. However, we felt the amount it offered him was an appropriate remedy to the inconvenience he suffered as a result of this.

Putting it right

Because we were satisfied that HMCTS had already made reasonable attempts to put matters right, we made no further recommendations.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 810/March 2015

Information Commissioner's Office got things wrong but corrected its error

Mr D complained to the Information Commissioner's Office (ICO) about an information request he made to a company for the recording of a telephone call. Mr D wanted a copy of the recording but was having difficulties in getting it from the company.

What happened

Mr D complained to ICO about a company that would not give him a recording of a telephone call. It was unclear at first who held the data, because the company was trading under a different name. When it was established who held the data, ICO made an assessment that it was unlikely the company had followed data protection law. Mr D and the company gave ICO more information and it opened a new assessment. The outcome of the assessment was that it was likely the company had followed data protection law. Mr D asked for a review of the decision and ICO said the assessment was incorrect because it had not looked at all of the information. ICO said its assessment was that it was unlikely the company had followed data protection law. ICO asked the company to respond to the information request.

What we found

We did not uphold this complaint. The second assessment was flawed because ICO had not considered all of the information. However, ICO put things right by reviewing the decision and correcting its error. We found ICO had met its obligations under the data protection law and it did not have to take any other action than complete the assessment.

Organisation(s) we investigated

Information Commissioner's Office (ICO)

Summary 811/March 2015

Information Commissioner resolved its confusing decision letter

The Information Commissioner's Office (ICO) made a reasonable decision about Mr P's case. But its first attempt to explain the decision was confusing. It was only after Mr P complained that it clarified the situation.

What happened

Mr P complained to ICO about his criminal record. He told ICO that the police had recorded he had pleaded guilty to actual bodily harm when in fact he had pleaded guilty to assault. He had given the police a copy of the court's Memorandum of Conviction, as well as a local newspaper report to support his view. The police asked the court for a copy of the court file, but it had been destroyed. The police therefore put forward a compromise. They would not change Mr P's record because they did not have the court file to do that. But they would keep his complaint on his criminal record so it was clear he disputed it.

Mr P complained to ICO. ICO decided the police had complied with the *Data Protection Act*. When ICO told Mr P about the decision, he did not understand the letter because it was full of legal quotations and language he did not understand.

Mr P complained and ICO sent him a better written letter explaining its decision more clearly. Mr P and ICO continued to correspond, until he eventually complained to us.

What we found

We did not uphold this complaint. We did not criticise ICO for the way it made its decision, which was fair and reasonable. However, ICO's first letter to Mr P was confusing, and it was not surprising that he complained. After he did that, ICO sent Mr P a much clearer decision, which gave him an explanation he could understand. In doing this, ICO resolved its original mistake.

Organisation(s) we investigated

Information Commissioner's Office (ICO)

Summary 812/March 2015

Unfortunate series of circumstances left student without leave to remain

Ms L complained about UK Visas and Immigration's (UKVI's) handling of her application for a student visa in summer 2009. She said that its mishandling had an impact on subsequent applications she made in 2009 and 2010.

What happened

Ms L made an in-time application for an extension to her student visa in summer 2009. However, the application was returned because of a problem taking payment for the application fee. In autumn 2009, Ms L submitted another application for a student visa, but her existing visa had expired in the summer of that year. UKVI accepted the application but refused the visa later in autumn 2009. This was because Ms L's college had its licence to sponsor student visa applications revoked in autumn 2009. The college's licence was reinstated the next month. Because Ms L's autumn 2009 application had been submitted after her leave to remain had expired, she was not entitled to appeal the decision.

Ms L then made another student visa application in early 2010 but this was refused because Ms L's course had started more than 28 days after her period of overstaying began.

From 2010, Ms L complained to UKVI about the problem taking payment for her first application. She considered that UKVI had made a mistake and that if that application had gone through, she would have been entitled to appeal the decision to refuse her visa. While she appealed, she would also have retained her existing leave to remain.

UKVI found no evidence that it made a mistake taking payment for the summer 2009 application. It considered that its decisions on Ms L's applications were appropriate.

Ms L currently has no leave to remain in the UK and has failed to report to the immigration authorities as she has been asked to do.

What we found

We did not uphold this complaint. The evidence of Ms L's payment for her summer 2009 application had been destroyed after 18 months in line with UKVI's guidelines. We did not find evidence to show that Ms L had asked UKVI to properly investigate the matter before 18 months had passed. Therefore, there was insufficient evidence for us to find that UKVI's handling of the summer 2009 application was unreasonable.

As Ms L's subsequent application from autumn 2009 was made after her leave to remain expired, UKVI's decision to refuse the application without full appeal rights was correct.

UKVI's guidance from 2009 showed that only those with over six months leave to remain left were offered 60 days grace period to find alternative college courses, when a college's licence to sponsor students expired. As Ms L had less than six months leave to remain when she made both her summer and autumn 2009 applications, UKVI followed procedure by not offering her 60 days grace. It was reasonable that it refused her autumn 2009 application.

Ms L tried to make a third application in early 2010, but she fell foul of the *Immigration Rules* because the application was made more than 28 days after her previous leave to remain expired.

While Ms L was unhappy that UKVI had retained her passport, legislation states that it can do this when a person has overstayed their leave to remain.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 813/March 2015

Ofcom resolved its communication shortcoming

Ofcom failed to tell Mr N when it had finished investigating his concerns, but resolved this when he later complained.

What happened

Mr N's hobby is amateur radio. He reported interference to his radio to Ofcom, and it investigated. Mr N was unhappy about the way Ofcom had investigated his case. He had an argument with two Ofcom engineers about this when they visited his home. As a result they cut their visit short. Mr N was unhappy about this, and said Ofcom had been rude to him. Mr N heard nothing from Ofcom the next time he complained about interference, and he assumed it had decided it would not deal with him in future. He complained to Ofcom about what happened, and it confirmed that it had investigated his concerns. Mr N challenged Ofcom's technical assumptions about that visit and was unhappy with what it told him. He therefore complained to us.

What we found

We did not uphold this complaint. Ofcom investigated Mr N's concerns properly, and we made no findings about the argument Mr N had with the Ofcom engineers, because there was no impartial evidence available. Ofcom had not decided it would not deal with Mr N in the future. However, it had not told Mr N when it had completed its investigation of his latest concerns. This was a shortcoming, but it was one Ofcom resolved when it told Mr N what had happened in a response to his complaint. We also found Ofcom's response to Mr N's technical queries (which were to support its engineers' qualifications and training) was appropriate.

Organisation(s) we investigated

Office of Communications (Ofcom)

Summary 814/March 2015

Student Loans Company recognised its delay caused student inconvenience, but it did not misadvise him

Mr T applied for student finance for a second university course in one academic year. He said the Student Loans Company (SLC) misadvised him about his application and he started his course without knowing whether it was successful. The SLC acknowledged a delay, but said it had not misadvised him.

What happened

Mr T started a university course in one academic year, but then dropped out. A few months later, in the same academic year, he started another course at a different university. He applied for student finance, but heard nothing in the weeks leading up to starting his new course. With two weeks to go, he telephoned the SLC to find out what was going on, because he needed to give confirmation of his student funding to his new university.

The SLC told Mr T that it would consider his application and would send him an acknowledgement email in two or three days to confirm it had received it. Mr T said the SLC told him he could use this to show the university his student funding was confirmed.

However, Mr T did not receive an email in two or three days. He got one in three weeks, which told him how much student funding he had received that academic year. He thought this email was the acknowledgement he had been promised. He showed it to his new university. However, two months later, the SLC told Mr T and his new university that it was not awarding him student finance for that financial year. The university asked Mr T to pay the tuition fees, but he could not do this.

Mr T complained to the SLC about the situation. He said the SLC had misadvised him, and led him to believe he would receive student funding, when he did not. His case was eventually considered by the SLC's independent assessor who found that Mr T had not been misadvised. Mr T had not received student funding because he had already received the equivalent of two years of funding, and could only receive a maximum of one more year. As his new course was a two-year course, the SLC could fund one, but not both years. The independent assessor also found Mr T had not been misadvised, but there had been a delay in approving Mr T's application. As a result of the inconvenience Mr T suffered, the SLC offered him a compensation payment of £25.

What we found

We did not uphold this complaint. The independent assessor was correct, Mr T had not been misadvised.

When Mr T received the email, he also got a copy in the post. If he had read both of those versions in full, he would have found out it referred to his previous university, which he had dropped out of earlier that year. If he had not understood the letters, he should have contacted the SLC to confirm what was happening. He did neither of those things.

The SLC acknowledged it took it some time to complete Mr T's application. It should have done this sooner, and this caused Mr T some inconvenience. It therefore offered him £25 compensation for that. We found this was a suitable sum to offer for that fault.

Organisation(s) we investigated

Student Loans Company Ltd (SLC)

Summary 815/March 2015

Student Loans Company acknowledged its adviser made the wrong assumption about Mr A's case

Mr A applied to the Student Loans Company (SLC) for a student grant. When he received no money he telephoned the SLC to find out what had happened.

What happened

Mr A was studying for a two-year course. In the first year he applied to the SLC for student finance and received a grant of approximately £500. The next year he applied again, but received nothing. When he telephoned the SLC to query this, the adviser assumed Mr A's household income was zero, without asking him for any evidence. Mr A therefore received a student grant of approximately £3,000. Mr A queried this, but was told it was correct.

When Mr A finished his course, he gave the SLC his financial information for the year. When he did this the SLC discovered it had overpaid his student grant by approximately £2,500. It asked Mr A to repay this sum. He complained because he believed it was not his mistake that had caused the overpayment. The SLC apologised for what had happened and offered Mr A £100 for the inconvenience he had suffered. However, it did not waive Mr A's overpayment.

Mr A asked the SLC's independent assessor to investigate the case. It upheld the SLC's original decision. Mr A therefore complained to us. Mr A also complained about the SLC's handling of his case.

What we found

We did not uphold this complaint. The SLC had not given Mr A any funding for the second year of his course because he had not completed the application forms. The SLC was not at fault on this. However, it was at fault when Mr A telephoned it, because the adviser he spoke to made a wrong assumption. The adviser assumed Mr A's household income was zero. In fact it was not. But the adviser told Mr A the assumption he was making, and Mr A did not challenge the assumption. The SLC therefore paid Mr A nearly £3,000 in student grant. The mistake was only discovered when Mr A finalised his grant when he finished his course. At this point, the SLC found out Mr A had been overpaid about £2,500. It asked him to pay this back.

It was reasonable for the SLC to ask Mr A to pay back the overpayment. He had effectively received an interest-free loan from the SLC, and there was nothing wrong with asking him to pay back money that he was not entitled to.

The SLC had dealt with Mr A's complaint appropriately, and it was reasonable for it to offer him £100 as compensation for the inconvenience he suffered. Mr A said the SLC had not answered many of his questions. We found the SLC acted reasonably when it did this, but we asked for more information to answer those questions, and we passed that on to Mr A.

Organisation(s) we investigated

Student Loans Company Ltd (SLC)

Summary 816/March 2015

Getting it almost right

Mr E complained that UK Visas and Immigration (UKVI) did not properly handle his application for a tier 1 (entrepreneur) visa in 2013. He said that he was not asked to provide relevant evidence and that UKVI did not provide satisfactory explanations during the complaints process.

What happened

In late spring 2013, Mr E's tier 1 (entrepreneur) migrant application was refused without a right of appeal. UKVI said that Mr E failed to include marketing material or evidence of contracts. It also said that he had provided bank statements for him and his entrepreneurial team member that were not in joint names. Mr E and his entrepreneurial team member both needed to show that they had £50,000 available to both of them.

Mr E complained and received responses from UKVI. UKVI advised that his application form referred him to the tier 1 guidance and the Immigration Rules, which showed that he needed to provide marketing material and evidence of contracts. It also said that while Mr E provided a declaration to say that the funds were available to both team members, the bank statements did not show that.

Mr E considered that UKVI should have applied its policy of evidential flexibility, which states that if documents are in the wrong format or one document from a series is missing, UKVI should ask the applicant to provide it before refusing the application.

UKVI gave contradictory replies. It first said that it would not have applied evidential flexibility to the issue of the marketing material. It then said that it would. It also, wrongly, said that Mr E had provided evidence of contracts and apologised to him for that. However, UKVI considered that Mr E still had not met the financial requirements because the funds were not in joint names for the entrepreneurial team.

What we found

We did not uphold this complaint. UKVI correctly pointed out that the application form Mr E used pointed him towards the tier 1 guidance and the Immigration Rules, which stated he needed to supply marketing material and evidence of contracts. We considered UKVI's decision on these actions was appropriate.

The guidance was clear that an entrepreneurial team needed to supply evidence of funds through joint accounts or third parties, but team members themselves could not act as third parties to each other. We considered that Mr E's bank statements showed that he could not demonstrate that he had access to the required funds.

We noted that UKVI was inconsistent about whether Mr E supplied evidence of contracts, and whether it would apply evidential flexibility in relation to the marketing material, which was unhelpful. However, we said that Mr E's application would still have been refused because of his failure to show evidence of access to funds.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 817/March 2015

Debt should not have been referred to bailiffs

After a court judgment that he did not know about, Mr A complained that court bailiffs caused him distress.

What happened

Mr A committed a driving offence. He was not told about the hearing and so did not attend. The judge ordered him to pay a fine. Mr A complained to HM Courts & Tribunals Service (HMCTS) that he did not know about the hearing. HMCTS responded to Mr A's letter saying that the fine was still payable and that he should contact it to arrange payment. However, HMCTS had also referred the matter to bailiffs for enforcement action. Mr A said that while he was still appealing the decision, HMCTS did not stop the bailiffs visiting him and did not tell him how to get the judgment cancelled until some months later.

What we found

Had HMCTS responded properly to Mr A's complaint that he was not aware of the hearing, the matter would never have been referred to the bailiffs for enforcement action. Mr A found the bailiff's visit particularly distressing because he was a vulnerable person in a remote area, who was wary of interaction with organisations. HMCTS's complaint handling was extremely poor and caused Mr A frustration, inconvenience and a loss of faith in the system.

Putting it right

HMCTS apologised to Mr A and paid him £500.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 818/March 2015

Request for reimbursement of hearing fee after case adjourned at the last minute

Mr B complained that HM Courts & Tribunals Service (HMCTS) adjourned the hearing of his small claims case on the day of the hearing. He said that he felt forced to settle his claim and asked HMCTS to reimburse his hearing fee.

What happened

Mr B's small claims case was due to be heard in autumn 2013. However, on the day of the hearing, HMCTS told him that the case had to be adjourned because another urgent case had to take precedence. Mr B said that he and the defendant had felt so emotional and stressed by the matter that they decided to settle the case that day. Mr B said that they were rushed before the judge to approve the settlement so they did not have time to discuss fees and expenses.

Mr B complained to HMCTS and asked for a refund of his hearing fee. He received a number of responses all declining to reimburse his hearing fee. HMCTS said that the hearing fee was payable when the matter was listed and that if Mr B had not settled on the day of the hearing, another hearing date would have been set. HMCTS also said that Mr B had not settled his case more than seven days before his hearing and that any court costs should have formed part of his settlement costs with the defendant.

What we found

We did not uphold this complaint. The decision to adjourn Mr B's hearing was a judicial one and not one taken by HMCTS. However, it was HMCTS's role to communicate the judge's decision. We noted that there was no evidence about HMCTS's actions on Mr B's court file and that the original court list had since been destroyed. It was not uncommon for the courts to adjourn cases when emergencies occurred, such as child at risk cases. We also saw no reason to question HMCTS's explanations or actions about the adjournment of Mr B's case.

HMCTS's guidance stated that a hearing fee could be reimbursed if a case was settled at least seven days before the hearing. We understood that as Mr B had not received a hearing, he wanted a refund. However, the reimbursement of costs was aimed at those who did not intend to proceed to a hearing, which clearly did not apply to Mr B, who wanted his hearing. There was no evidence that HMCTS had failed to follow its procedures in adjourning the hearing. We also noted HMCTS's explanation that Mr B could have included his costs as part of the settlement figure with the defendant. For these reasons, we considered HMCTS's decision to refuse to reimburse Mr B's court costs was reasonable.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 819/March 2015

Queries about a report from Cafcass

The Children and Family Court Advisory and Support Service (Cafcass) failed to recognise or correct inaccuracies in its report.

What happened

Cafcass wrote a report telling the court about its decision on whether Ms J's son should have contact with his father. The report contained information about the father's problems with alcohol. Ms J complained to Cafcass that the information in the report did not accurately reflect what the professionals helping the father had said about his alcohol consumption. Cafcass did not accept that it had made a mistake.

What we found

We did not uphold this complaint. Although some of the information in the report about the father's alcohol problems was not accurate, we did not consider that this amounted to maladministration. Nevertheless, we felt it should be put right and we asked Cafcass to send a letter to the court with the right information about the father's alcohol problems.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Under embargo until 00.01 Thursday, 22 October 2015

Complaints about the NHS in England

Summary 820/February 2015

Patient had procedure that was not necessary and that he had not consented to

Mr J complained that he had an unnecessary procedure that caused him pain for a year and resulted in two months of treatment.

What happened

Mr J had been treated with internal radiotherapy for prostate cancer. In 2013 he had a colonoscopy, an examination of the inside of the colon, as part of the NHS bowel cancer screening programme. During the colonoscopy, doctors found that Mr J had radiation telangiectasia (small widened blood vessels caused by the radiotherapy). They cauterised the area using a process called argon plasma coagulation (APC), a controlled burning of the superficial tissue. Mr J said this treatment was inappropriate and that it was carried out without discussion or his consent.

Mr J experienced severe pain and bowel problems for a year after the procedure was carried out. Doctors subsequently found that Mr J had a complication of APC, and he had two months of therapy using oxygen to treat this. The treatment took place for five days a week over a period of two months and was carried out at a hospital approximately 100 miles from Mr J's home.

While the treatment was successful, this was a very stressful time for Mr J and he incurred significant costs, including accommodation and travel expenses.

What we found

There was a failure to get Mr J's informed consent for the APC procedure. In addition, the information available to the consultant at the time did not support the use of APC in Mr J's case.

As a result of these failings, Mr J was denied the opportunity to make a fully informed decision about his treatment. APC was an inappropriate procedure for him, and it caused his subsequent bowel problems and the associated pain. He suffered distress and financial costs in having to have oxygen therapy to treat this.

The Trust had taken appropriate action to learn from the failings we had identified. The consultant gastroenterologist who had carried out Mr J's procedure had discussed the case with colleagues, and reviewed published literature on the subject. In addition, the Trust issued a circular to relevant medical staff advising that any heat therapy such as APC should not be routinely used on radiation induced gastrointestinal disease. However, we found that the Trust had not done anything to address the personal injustice it had caused Mr J.

Putting it right

The Trust wrote to Mr J to acknowledge the failings and apologise to him for the impact this had on him. It also paid Mr J £4,000 to cover the cost of accommodation, travel and other associated expenses he incurred while having the oxygen treatment.

Organisation(s) we investigated

Colchester Hospital University NHS Foundation Trust

Location

Essex

Region

East

Summary 821/February 2015

Practice failed to investigate cancer symptoms early enough

A GP practice did not follow national guidance when it investigated Mr A's symptoms and this delayed his diagnosis of cancer. A paramedic from the Ambulance Trust did not communicate appropriately with Mr A and his family.

What happened

Mr A's GP Practice did not investigate his cancer symptoms soon enough. Mr A had a history of chest pain and his family called an ambulance. They said the paramedic failed to communicate appropriately, so the family asked him to leave before completing his assessment, which meant a delay in Mr A going to hospital. Mr A deteriorated rapidly and did not receive his diagnosis until shortly before he died.

What we found

The Practice did not follow National Institute for Health and Care Excellence (NICE) guidance when it investigated Mr A's cancer, and this delayed his diagnosis. His family were unable to prepare for his death with him, and lost the chance to say goodbye. We did not uphold the complaint against the Ambulance Trust because, although there were failings in the paramedic's communication skills, the Ambulance Trust had taken sufficient steps to prevent this happening again.

Putting it right

The Practice acknowledged its failing, apologised and paid the family £1,000 to recognise the impact of Mr A's death, and for the bereavement, anxiety and distress they suffered. The Practice also set up a training programme to identify 'red flags' (signs of a serious underlying condition) in a cancer investigation.

Organisation(s) we investigated

West Midlands Ambulance Service NHS Foundation Trust

A GP practice

Location

West Midlands

Region

West Midlands

Summary 822/February 2015

Patient did not get complete information on dental treatment options or a response to his complaint

When Mr C's dental bridge fractured, the dentist repaired it but did not tell him the repair might not last, or the likely cost of replacing it at a future date. The Practice also failed to respond to Mr C's subsequent complaint in line with NHS regulations.

What happened

When Mr C was having a crown fitted, he told the dentist that he also had a fractured bridge. The dentist repaired the bridge but it needed replacing within 12 months and Mr C incurred a further £209 charge for this. Mr C complained to the Practice but did not receive a written response to his complaint.

What we found

We partly upheld this complaint. Mr C should have been informed that the bridge repair might not last and given the option of a replacement as an alternative to a repair. When Mr C complained about the additional cost he incurred when his bridge was replaced, the Practice did not provide a written response explaining how the complaint had been considered and conclusions reached, as it should have done in accordance with NHS regulations.

Putting it right

Following our investigation, the Practice apologised to Mr C and reimbursed the charge for his replacement bridge. It also paid him compensation of £500 for the upset and frustration caused by its failure to respond to his complaint properly. The Practice drew up plans to improve its service.

Organisation(s) we investigated

A dental practice

Location

Merseyside

Region

North West

Summary 823/February 2015

Mental health patient denied fair risk assessment after alleged knife incident

The Trust withdrew Ms Z's crisis support from her home after an incident in which she allegedly pointed a knife at a member of staff. Although Ms Z was not left without adequate support, staff did not assess the risks properly and the Trust did not revisit its decision to withdraw crisis support.

What happened

Ms Z had been receiving crisis support from the Trust for a number of years. This was usually in the form of somebody going to her home to complete a welfare check, and to help her in times of crisis. On one such occasion, a care worker reported that Ms Z had pointed a knife at her. This prompted the Trust to withdraw home support. It told Ms Z that she would have to attend a safe environment if she wished to get support.

This continued for a number of months and Ms Z became more upset at the situation. She felt she was being penalised for an incident that was never proven.

What we found

We partly upheld this complaint. The Trust acted appropriately by initially withdrawing home visits, but there is no evidence it later reassessed the risks. Although we could not say that the care and support Ms Z received was inadequate during this time, we did not see any evidence to justify the continued blanket withdrawal.

Putting it right

The Trust apologised to Ms Z for the failings we identified. It completed a new risk assessment and used this to reconsider whether Ms Z's current crisis plan was sufficient. The Trust also formulated an action plan to show how it would make sure it completed appropriate risk assessments in future.

Organisation(s) we investigated

Barnet, Enfield and Haringey Mental Health NHS Trust

Location

Greater London

Region

London

Summary 824/February 2015

Patient died after Trust failed to treat sepsis appropriately

Miss L complained that her father, Mr L, did not receive the correct treatment when he went to hospital with a lump on his buttock, and that he was discharged so soon.

What happened

Mr L went into hospital with a painful lump on his buttock, and tests showed that this was an infection. Doctors tried to remove fluid from the lump but were not successful. Staff did not feel surgery was needed and discharged Mr L home with antibiotics. He returned to hospital three weeks later with intense pain in his foot. Clinicians found that the infection had spread, and Mr L died a few days later.

Miss L complained to the Trust because she felt the Trust should have treated her father's infection better and should not have sent him home after his initial admission to hospital. The Trust said the two admissions were unconnected. It said that the infection Mr L had on the second admission was a fast-acting infection that would have spread quicker than the three weeks between admissions.

Miss L thought that the lack of care and treatment the Trust provided led to her father's death. She was not happy with the Trust's explanations and wanted further explanations and an apology.

What we found

On his first admission to hospital, Mr L showed signs of sepsis. The Trust did not treat this appropriately and should not have sent Mr L home without surgery or appropriate treatment. The subsequent infection was linked to the first admission. The lack of appropriate treatment when Mr L was first in hospital compromised his chances of survival.

Putting it right

The Trust apologised to Miss L and paid her £2,000 compensation. It also drew up plans to address its shortcomings.

Organisation(s) we investigated

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 825/February 2015

Patient with bleeding on the brain not treated early enough

Mrs G complained that medical staff failed to recognise the possibility that her father, Mr P, had an intracerebral bleed (bleeding within the brain) and did not take early action to diagnose and treat this.

What happened

Mr P collapsed at home and was taken to A&E. At the time he was taking warfarin (a blood-thinning medication). The A&E doctor who first assessed him made a provisional diagnosis of syncope (loss of consciousness) possibly due to a cardiac cause and dehydration, and referred him to the on-call medical team for assessment. A second doctor noted that Mr P's blood results showed a high international normalised ratio (INR) level (a test for blood clotting). Just over an hour later, a specialist registrar saw Mr P and requested an urgent CT scan in order to exclude the possibility that he had had an intracerebral bleed. However, the radiology department was not told that this scan was urgent. The scan was eventually scheduled for about two hours later.

Mr P's condition deteriorated and so the scan was delayed. The medical team reviewed him and gave him vitamin K which helps the blood to clot. When the scan was done it showed a large intracerebral bleed. Doctors gave him medicine to reverse the effect of warfarin in order to try to halt the bleeding, and contacted the neurosurgeons. The neurosurgeons considered that surgery would not benefit Mr P. He fell into a coma and, despite treatment, did not regain consciousness. He died the following day.

What we found

We partly upheld this complaint. There were failings in record keeping and in the medical and nursing care Mr P received. In particular there were missed opportunities to provide him with earlier investigations and treatment (the warfarin reversal agent), so that he could have had surgery.

Vital blood results were delayed by approximately an hour because staff had taken inappropriate samples. The second doctor who reviewed Mr P failed to act on his abnormal blood results or escalate his case for further urgent medical attention. This meant a registrar did not review Mr P for over an hour.

When a doctor asked for a CT scan, he did not tell the radiology team that it was urgent. Also, there was enough evidence to warrant giving Mr P the warfarin reversal agent before the CT scan. However, doctors did not give it to him at that time, which meant this was another missed opportunity to treat Mr P sooner.

We were unable to say what would have happened if the failings we found had not happened and Mr P had received earlier treatment. We did, however, find that the Trust had not done enough to address the impact of the failings on Mr P's family, or address the risks for future patients.

Putting it right

The Trust wrote to Mrs G to acknowledge the failings we found and apologised for the impact of these. It also paid her £400 in recognition of the ongoing distress she experienced as a result of the failings in her father's care. This was also to acknowledge the uncertainty about whether his outcome could have been different had the failings not occurred, and the way in which the Trust responded to her complaint.

The Trust prepared an action plan to show what it had done or planned to do to make sure that it had learnt from the failings.

Organisation(s) we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 826/February 2015

GP restarted older patient on blood pressure medication after she collapsed

Mrs T, who was in her nineties, complained to us, with the help of her representative, that her GP inappropriately prescribed her Doxazosin. She said this caused postural hypotension (a fall in blood pressure when she stood up) and led to her being admitted to hospital. When she was discharged, she had a stroke and had to live in a residential home. She said this caused her financial injustice because she had to fund her own residential home costs.

What happened

Mrs T was diabetic and had a history of high blood pressure. Her GP provided care and treatment not only when she was at home, but also in a residential care home and as an inpatient at a trust community hospital.

Mrs T's GP began prescribing Doxazosin to treat this in 2007. In late summer 2011 Mrs T experienced a loss of consciousness and was admitted to hospital. Clinicians felt that she had collapsed due to a combination of her blood pressure medication and having just eaten, and stopped the Doxazosin.

Mrs T was subsequently transferred to a Trust community hospital. Her GP (who was also contracted to work for the Hospital Trust) saw her and decided to restart her on Doxazosin because her blood pressure was high. The next day, the same GP decided to double the dose.

Mrs T stayed in hospital for about a month and experienced further collapses. She was discharged to a residential care home for respite care because she was unable to look after herself at home.

In winter 2011 Mrs T saw a consultant cardiologist. Following his advice, Mrs T's GP stopped Doxazosin in an attempt to improve her postural hypotension.

In early 2012 Mrs T was told that she had suffered a minor stroke caused by her high blood pressure. She remained at the residential care home until her death in winter 2014. We continued to investigate her case.

What we found

We partly upheld the complaint against the Hospital Trust as it employed the GP. The GP's decision to restart Doxazosin and then to double the daily dose went against the standards set out in the General Medical Council's *Good Medical Practice 2006*. This guidance says that doctors must only prescribe drugs or treatment when they have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs. We did not think that the GP acted in accordance with this guidance and we considered this fell so far below the relevant standard that it amounted to service failure.

However, it was not possible to say that restarting Doxazosin caused Mrs T to have a stroke. She was already at a greater risk of a stroke because of her age and her diabetes. There are a number of possible reasons why Mrs T suffered a stroke and it was not possible to link this solely to restarting Doxazosin.

When the consultant cardiologist wrote to Mrs T's GP and asked him to stop prescribing her Doxazosin, the GP Practice acted on this advice. We concluded that the Practice acted in line with established good practice in this instance, properly taking note of specialist advice. We therefore did not uphold the complaint against the GP Practice.

Putting it right

We did not make any recommendations as the failings did not result in an injustice.

Organisation(s) we investigated

A GP practice

Torbay and Southern Devon Health and Care NHS Trust

Location

Devon

Region

South West

Summary 827/February 2015

Dental practice did not leave hole in patient's tooth

Miss F complained that poor dental treatment left her with an unsightly hole in her tooth and made her feel conscious about her appearance.

What happened

Miss F went to her dental practice in spring 2014 to have treatment to a lower molar tooth. The decay was treated, her old filling removed and a new amalgam filling put in its place. Miss F was not happy with the treatment as she felt that a visible hole had been drilled in the side of the treated tooth. Miss F complained to the Practice. It said it was sorry that she was dissatisfied with the care and advice given, and explained that it had previously discussed her various options with her. The Practice said that during the course of the treatment Miss F was given a mirror to view the work, and that it was confident the treatment was in line with good clinical guidelines.

What we found

We did not uphold this complaint. The dentist treated Miss F appropriately and there was no evidence that the Practice failed to adequately address her concerns or that the treatment provided was not in accordance with good practice. Our clinical adviser said a previous X-ray suggested that Miss F had a defect in the filling and the dentist removed the decay in accordance with relevant guidance. As the decay had spread, it was necessary for the dentist to extend the filling and therefore drill in a different section of Miss F's tooth.

Organisation(s) we investigated

A dental practice

Location

West Midlands

Region

West Midlands

Summary828/February 2015

GP failed to give accurate explanation for deregistering patient

A GP practice decided to deregister two patients but did not explain why. The patients said that deregistering them was not justified.

What happened

Mr and Mrs G complained to the General Medical Council about their GP. The complaint was not upheld. Mr and Mrs G continued to be unhappy and considered that the GP was not competent and should undergo further training.

The Practice partners held a meeting in light of Mr and Mrs G's concerns and decided that the relationship between the Practice and Mr and Mrs G had broken down and that it would deregister them as patients.

The Practice wrote to Mr and Mrs G and explained its decision. But it added that the partners' decision was also made as a result of a specific incident which occurred in the Practice waiting room. This was when Mrs G was overheard by staff calling the GP incompetent and suggesting she should be sacked.

Mrs G complained to us that the Practice's response was inappropriate and inaccurate and the decision to deregister her and her husband was unreasonable.

What we found

We partly upheld this complaint. We were satisfied that the decision to deregister Mr and Mrs G was reasonable since a clinician could not be expected to provide care to a patient who has no faith in his or her ability.

The Practice's explanation of why Mr and Mrs G were deregistered wrongly relied upon witness testimony of an incident that occurred in the Practice's waiting room. We established that in fact the incident occurred ten days after the Practice partners had decided to deregister Mr and Mrs G.

Putting it right

The Practice apologised to Mr and Mrs G for the inaccurate explanation, and explained how it would make sure that responses to complaints are based on evidence in the future.

Organisation(s) we investigated

A GP practice

Location

Norfolk

Region

East

Summary 829/February 2015

Trust failed to update GP details which led to wrong prescription

Mr F complained about the medication his father was taking, that it had been prescribed for too long, and the dose increased when it should have been decreased.

What happened

Mr F's father, Mr H, had been taking a certain medication for several years. When the GP increased his dose Mr H started to feel drowsy and lethargic, and had to go to hospital. Mr F complained that the medication was inappropriate, had been prescribed for too long, and the dose should not have been increased.

What we found

We partly upheld this complaint. The long term use of the medication was appropriate. However, because the Trust failed to update the new GP details when Mr H changed GPs, the new GP never received the letter from the Trust's doctor asking for the medication to be reduced. The medication should not have been increased.

As a result, Mr H became lethargic and sedated for several weeks, which caused his family unnecessary distress. The Trust failed to respond to Mr F's complaint that it had sent the letter to the wrong GP.

Putting it right

The Trust apologised to Mr F for its failings and for the impact this had on him and his family. It also explained how it intended to make sure that up-to-date GP details were recorded in the future.

Organisation(s) we investigated

5 Boroughs Partnership NHS Foundation Trust

Location

Warrington

Region

North West

Summary 830/February 2015

Clinical Commissioning Group failed to provide an appropriate refund for nursing home costs

Ms R complained that the Clinical Commissioning Group (CCG) had failed to meet the full cost of her father's nursing home care, although he was eligible for NHS continuing care funding.

What happened

Mr V was living in a nursing home and was found eligible for NHS continuing care funding from spring 2013. However, as he had moved to another region, the CCG where he had previously lived only became aware in autumn 2013 that it was responsible for meeting his healthcare costs.

During this period, spring to autumn 2013, Mr V paid for the cost of the nursing home. Ms R submitted the invoices for the fees he had already paid to the CCG. The CCG said it had agreed with the nursing home that Mr V's care costs were £800 a week. Therefore, the CCG only refunded the invoices to Mr V up to this amount. After refunding this money, the CCG then started to pay the nursing home £800 a week for Mr V's ongoing care.

However, the actual fees the nursing home charged were £1,680 a week, and it disputed that it had agreed a lesser charge with the CCG. The nursing home invoiced Ms R for the outstanding costs which were not covered by the CCG's payments.

What we found

In accordance with the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care, the CCG was responsible for meeting the full costs of Mr V's care. The CCG had unnecessarily delayed sorting this out and had failed to give Mr V an appropriate refund. It was the CCG's responsibility to meet the ongoing costs of Mr V's care, but it took no action when Ms R told it that it was not meeting these.

Putting it right

The CCG apologised to Ms R for its failings and for the injustice it caused her. It paid Ms R £500 in recognition of the frustration she had experienced from the delays, and the CCG's poor handling of this case. The CCG also refunded Mr V the fees he had wrongly paid for his nursing home care (over £102,000) and agreed to continue to meet Mr V's care costs.

Organisation(s) we investigated

South Lincolnshire Clinical Commissioning Group (CCG)

Location

Lincolnshire

Region

East Midlands

Summary 831/February 2015

Trust unreasonably refused to respond to complaint

Miss B complained that the Trust declined to investigate her concerns about the care and treatment her late mother received in 2009 because it said her complaint was 'out of time'.

What happened

Mrs B was an inpatient at the Trust in 2009. She died while she was in hospital. Miss B said that at the time, staff were unable to explain what had happened or why her mother's condition suddenly deteriorated.

Soon after, Miss B had serious and debilitating health problems of her own. She said that this prevented her from making a complaint about her mother's care and treatment.

Miss B complained to the Trust in autumn 2012. It said that her complaint could not be investigated because complaints had to be made within 12 months, and hers was therefore 'out of time'.

What we found

The regulations that set out how NHS complaints are handled do have a time limit for making complaints. However, the regulations also say that the time limit shall not apply if the responsible organisation is satisfied that the complainant had good reasons for not making the complaint within that time limit. Also that it is still possible to investigate the complaint effectively and fairly, in spite of the delay.

The Trust failed to ask Miss B about the reasons for the delay in making her complaint. Also, the Trust's response to her complaint did not clearly explain the reasons for not investigating the complaint, and incorrectly said that it was not possible for it to look at the complaint. We considered that Miss B had legitimate reasons and good evidence for not complaining sooner. Her concerns could have been addressed using the available medical records.

Had the Trust asked Miss B about the reasons for not complaining sooner, it would have been appropriate for the Trust to investigate and respond to her concerns.

The Trust's faults meant that Miss B still did not have answers to her questions about her mother's care, which was a continued source of distress for her.

Putting it right

The Trust apologised for the distress and inconvenience caused to Miss B as a result of the faults identified and paid her £200 compensation. It also reconsidered its decision not to investigate her complaint about her mother's care, and produced an action plan to address the faults in complaint handling identified in our report.

Organisation(s) we investigated

University Hospitals of Leicester NHS Trust

Location

Leicester

Region

East Midlands

Summary 832/February 2015

Family prevented from using cream of choice on son's eczema

When Ms P and Mr Q wanted to use unpreserved creams on their son's mild eczema, it was treated as a safeguarding matter by the Trust.

What happened

Ms P and Mr Q's son, who suffered from eczema, was under the care of a consultant dermatologist, because he had a severe skin infection. Ms P and Mr Q wanted to use an unpreserved herbal cream on their son's skin and not use the medicines prescribed. The dermatologist warned them that unpreserved creams are more likely to become contaminated with bacteria and cause infection. He told them that if their son became ill again, and they refused to follow medical advice it would be a child protection issue.

Ms P and Mr Q complained about how they had been treated. The Trust invited them to a meeting in its Child Assessment Unit, attended by the dermatologist and a paediatrician who was its safeguarding lead. They strongly advised Ms P and Mr Q to stop using the herbal cream but told them that the matter was not being treated as a safeguarding matter. Ms P and Mr Q complained that they had been unfairly denied the opportunity to use their preferred cream on their son's skin, because the Trust had dealt with the matter as a safeguarding issue. Responding to their complaint, the Trust confirmed that the use of unpreserved cream was a safeguarding matter.

What we found

There was insufficient evidence to justify dealing with the family's preference for unpreserved creams as a safeguarding matter. The Trust had been inconsistent in its communications with the family as to whether or not the matter was one of safeguarding or not. This prevented the family from using their chosen cream, and caused frustration and distress.

The Trust took too long to respond to Ms P and Mr Q's complaint, and its response was not customer-focused or objective because it failed to get an independent opinion.

Putting it right

The Trust apologised to Ms P and Ms Q for the mistakes and for the distress caused. It also paid them £500 compensation.

Organisation(s) we investigated

Sheffield Children's NHS Foundation Trust

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 833/February 2015

Failings in care of older patient

Mrs N was distressed by the nursing and medical care her mother received during an inpatient hospital stay and also by failings in record keeping and communication.

What happened

Mrs N's mother, Mrs R, was admitted to hospital with a fractured hip after a fall at home. She had surgery to repair the fracture and stayed in hospital for two and a half months before she was discharged to a nursing home. During her admission to hospital, Mrs R experienced symptoms of a suspected stroke, followed by a confirmed stroke four days later.

Mrs N complained about the timing of her mother's operation; provision of traction; prescription of a blood thinning medication; pressure area care; communication between her and the staff caring for her mother; monitoring of her mother's condition; stroke prevention and care; diabetes management; and record keeping. She also complained about the Trust's response to her complaint.

What we found

We partly upheld this complaint. There were no failings with the timing of Mrs R's operation, provision of traction, prescription of blood thinning medication or pressure area care. There were, however, shortcomings in record keeping, aspects of the Trust's communication with Mrs N, the lack of medical review after suspected stroke symptoms, adherence to the guidance in relation to the administration of medication to manage stroke and diabetes, and the Trust's investigation of Mrs N's complaint.

The failings identified did not affect Mrs R's outcome, but did add to Mrs N's distress.

Putting it right

The Trust apologised to Mrs N for its failings, and paid her £400 compensation.

It also prepared plans to demonstrate how the learning from her and Mrs R's experience could make sure that poor service is not repeated.

Organisation(s) we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 834/February 2015

Standard of Trust's mental health assessments questioned

Miss S complained about the standard of two psychiatric assessments and said she received inappropriate, prejudicial and judgmental comments. She said failings stopped her from getting the help she needed.

What happened

Miss S said that on two occasions the psychiatrist failed to ask sufficient questions to understand whether she was at risk of self-harm. She also said that the psychiatrist's subsequent report contained inaccurate information about her mood when she was assessed, and her thoughts of self-harm.

Miss S also complained that an approved mental health practitioner made comments about her lifestyle and life choices rather than helping her find the right therapy.

What we found

We partly upheld this complaint. The records of the assessment did not contain enough information and explanation to show that the relevant standards were met, and the Trust had not recognised that failing.

Although we could not say that this failing had put Miss S at greater risk, we were satisfied that she had been left with the uncertainty of not knowing if things could have been different.

We were unable to come to a definitive view about the comments made by the approved mental health practitioner but we recognised that Miss S found this intervention unhelpful.

Putting it right

The Trust wrote to Miss S to apologise for the upset, worry and uncertainty and paid her £200. It also took action to show that it had learnt lessons from Miss S's complaint.

Organisation(s) we investigated

Cheshire and Wirral Partnership NHS Foundation Trust

Location

Chester

Region

North West

Summary 835/February 2015

Trust provided good clinical care but failed in complaint handling

Mr A complained about his wife's care but it was the Trust's complaint handling that proved to be the actual failing.

What happened

Mrs A had a stroke and was treated at an acute stroke unit. She was transferred to the Trust as an inpatient and fed via a nasogastric tube (a tube that passes from the nose into the stomach) because of her difficulty in swallowing. Mrs A remained at the Trust until she passed away two and a half months later. During that time plans had been made to discharge her to a care home, but in the event she was too poorly for this to be followed through.

Mr A was concerned that his wife did not receive adequate levels of care from the Trust's speech and language therapists who were helping her because the stroke had affected her speech. He felt that Mrs A should have received particular care as she was being fed via a nasogastric tube. Mr A said that this was made worse by a number of changes to the therapy personnel. He also felt that more attempts should have been made to introduce her to solid feeding.

Mr A also complained about the time it took the Trust to respond to his complaint.

What we found

We partly upheld the complaint. The Trust's records showed that Mrs A received appropriate care throughout her stay and that this was continuous despite the staff changes. There were no failings in the care and treatment or the method of feeding.

The Trust took far too long to respond to Mr A's complaint and failed to adequately explain the delay.

Putting it right

The Trust apologised to Mr A that its handling of his complaint took far too long. It also has drew up plans to avoid a recurrence of these failings.

Organisation(s) we investigated

Homerton University Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 836/February 2015

Trust failed to fully recognise the impact of its poor communication

Ms H complained about the care and treatment she received when her fibroids were removed. She said she was unprepared for the procedure, the complications, and the significant scar on her abdomen. She also said that the Trust dealt with her complaint poorly.

What happened

Ms H was told at a preoperative assessment that after her fibroids were removed she would be discharged from hospital within 24 hours and could go back to normal activities shortly afterwards.

After her operation, Ms H stayed in hospital for over a week before she was fit to be discharged. She then experienced pain, swelling and bleeding, and was readmitted to hospital. She had to have more surgery for debridement of the operation site (removal of dead tissue to help healing).

Ms H was left with a significant scar that caused discomfort when she wore certain clothing, and this distressed her because she said it was so ugly.

What we found

We partly upheld this complaint. Ms H was not properly told about what to expect before her operation, or about any of the possible complications. As a result of this, she was very distressed when a known complication occurred that she was not aware of.

There were some failures in the standard of nursing care she received after the operation, and not all postoperative checks were carried out. The Trust failed to manage Ms H's subsequent complaint in line with the NHS complaint regulations, causing her further distress.

However, the clinical treatment Ms H received was entirely appropriate and the operation and the debridement were carried out to the expected standard.

Putting it right

The Trust did further work to make sure it gives patients accurate and complete information about the procedure before the operation, including any possible known complications. It also took steps to make sure that all postoperative checks are carried out.

Organisation(s) we investigated

United Lincolnshire Hospitals NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 837/February 2015

GP Practice failed to appropriately monitor patient who was on a potentially fatal drug

Although Ms J was prescribed a dangerous drug to control her rheumatic condition, her GP failed to monitor her or take appropriate action. When she complained, the local Area Team took a long time to deal with her complaint.

What happened

Ms J was prescribed methotrexate which is an anti-rheumatic drug that reduces the activity of the body's immune system. It can affect the blood count and liver function, and make patients more vulnerable to infections. A rheumatology clinical specialist nurse at the Trust reviewed Ms J regularly and liaised with her GP Practice under a shared care scheme. The Practice prescribed the drugs and carried out regular fortnightly blood tests.

When Ms J found out her blood test results showed some serious problems, she contacted the nurse who told her to stop taking the methotrexate immediately.

Ms J's blood test results had also shown serious problems on other occasions, but the Practice had not contacted Ms J or the nurse to tell them.

When the Practice stopped seeing Ms J under the shared care system she thought it was because she had complained about what had happened. She complained to the local Area Team and it took over six months to send Ms J a final response to her complaint

What we found

The Practice had not taken appropriate action when Ms J's blood test results showed problems that could have led to significant liver damage. Also, the local Area Team had not handled Ms J's complaint in line with the *Local Authority Social Services and NHS Complaints (England) Regulations 2009*.

Putting it right

The Practice apologised to Ms J and paid her £500 compensation. It also put an action plan in place to learn lessons from the failings and make sure they did not happen again.

The local Area Team apologised, paid Ms J £250 for its poor complaint handling, and put an action plan in place to improve its complaint handling.

Organisation(s) we investigated

A GP practice

NHS England (Lancashire Area Team)

Location

Blackburn with Darwen

Region

North West

Summary 838/February 2015

Dental Practice did not appropriately discuss patient's medical condition before treating her

The Dental Practice and dentist did not follow established good practice in discussing patient's blood disorder when planning treatment, and tests had to be done as an emergency.

What happened

Miss W had a blood condition noted on her records at the Practice, but when the dentist suggested two extractions she failed to discuss with Miss W the need to take precautionary blood tests first. Miss W told us that removing teeth could cause persistent bleeding if her blood condition was not treated in advance.

Miss W had to have the blood tests done as an emergency at hospital rather than having them done locally. This meant that Miss W was without her denture for an extra two days and had expenses because of taking time off from work and her travel costs.

Miss W complained, and said the Practice took a long time to deal with her complaint.

What we found

We partly upheld this complaint. The dentist failed to discuss the medical history form with Miss W before the treatment. However, Miss W had signed a treatment plan agreeing to the extractions. Miss W suffered distress and inconvenience as a result of the failing, and out-of-pocket expenses. She had to make two trips to hospital to have the tests done hurriedly, rather than at her local surgery. She was also without her denture for more than one day. The Practice had put remedial actions in place as a result of the complaint.

The Practice and dentist acknowledged delays in the complaint handling process.

Putting it right

The Practice apologised for its failings and paid £100 compensation. The dentist agreed to give further apologies, prepare a personal development plan and take training to avoid future incidents.

Organisation(s) we investigated

A dental practice

Location

Devon

Region

South West

Summary 839/February 2015

Dental Practice failed to record consent for removing a bridge

Mrs G was upset that her bridge had been removed, and the Practice's response to her complaint was poor.

What happened

Mrs G complained that a dentist removed her bridge and remaining rods during a consultation in early 2012, even though she explained that she could not wear dentures because she had a bad gag reflex. She said the dentist did not fully explain what he was doing.

Mrs G said she has had a few sets of dentures since but she was unable to tolerate them. She explained that this was affecting her daily life; she could not eat properly; has had to liquidise her food; and she no longer wants to leave her house.

What we found

We partly upheld this complaint. The decision to remove the bridge was reasonable and there was no viable alternative under NHS dental provision. The dentist made Mrs G aware of this possibility on numerous occasions. However, the Practice failed to complete a treatment plan for the bridge removal and therefore did not record Mrs G's consent for this procedure.

The Practice's response to Mrs G's complaint was unsupported by any evidence as it stated that her oral hygiene was poor, without details of this in the records. It also failed to complete basic periodontal examinations for Mrs G, but as there was no evidence of bone loss or tooth or gum disease, we did not conclude that these or any other dental problems would have been found if these examinations had taken place.

Putting it right

The Practice wrote to Mrs G to acknowledge the identified failings and apologised for their impact on her. It also produced three individual action plans to address its failure to: provide evidence-based explanations within complaint responses; conduct basic periodontal examinations in line with guidance; and complete the appropriate records to show explicit consent for procedures has been gained.

Organisation(s) we investigated

A dental practice

Location

Lincolnshire

Region

East Midlands

Summary 840/February 2015

Patient unable to get support hosiery in the colour she was used to

Mrs J's choice of colour for her compression stockings was limited when the management of her condition changed from hospital to GP.

What happened

Mrs J said that she was able to wear the colour of stockings she preferred for twelve years when the hospital supplied them to her, but when her GP managed her condition she only had a choice of two colours, black and beige. She was willing to wear the black stockings during winter but the beige colour did not match her skin colour and she said they prevented her from wearing a skirt.

Mrs J complained to her local Clinical Commissioning Group (CCG) who tried to resolve the issue, but was unable to find out why there was a restriction in colour choice. It presumed that the local hospital had a supply of stockings or a separate ordering procedure, and only standard supplies were available to a GP on a prescription, or that the Department of Health had restricted the availability. But it did not confirm any of this.

What we found

We did not uphold this complaint. With the help of NHS Prescription Services (a service supplied by the NHS Business Services Authority), we found that the hosiery supplier had restricted the colour choice available to the NHS on prescription to two colours. This was not a decision taken by the NHS. We also identified that the hospital had a separate arrangement with the company which provided it with a wider range of colours.

Putting it right

We advised the CCG that it should have done more to clarify the situation and establish the cause of the restriction. However, it was not substantially at fault and this was a minor concern.

Organisation(s) we investigated

Wiltshire Clinical Commissioning Group (CCG)

Location

Wiltshire

Region

South West

Summary 841/February 2015

A mental health trust failed to adequately assess a patient and did not handle a subsequent complaint appropriately. An acute trust also failed to handle the complaint appropriately

Mr N complained that the Mental Health Trust failed to adequately assess his step-son's mental health before discharging him, and the Acute Trust failed to consider if he needed additional support. Shortly after leaving hospital, his step-son, Mr Y, committed suicide.

What happened

Mr Y was admitted to A&E at the Acute Trust after taking an overdose of paracetamol while he was drunk. A doctor reviewed him and gave him treatment to counteract the effect of the paracetamol. Mr Y was also referred to a mental health nurse from the Mental Health Trust for assessment. The nurse concluded that Mr Y was not at risk of further self-harm and could be discharged once he had completed his medical treatment. Mr Y was discharged from A&E after his treatment ended, but committed suicide shortly afterwards.

Mr N complained about the care Mr Y received, and this was the subject of two joint investigations by the Trusts. Mr N said that had the Trusts acted appropriately, Mr Y would not have killed himself. Mr N also complained about how both Trusts had handled his complaint. He said that if the Trusts had done what they should have, his family could have avoided unnecessary distress.

What we found

We partly upheld complaints against both organisations. The Acute Trust adequately considered Mr Y's condition before discharging him. But the Mental Health Trust failed to adequately assess Mr Y and take account of his physical health or a previous overdose, or ask questions about these issues. The Mental Health Trust also failed to give Mr Y information on what to do should he suffer a crisis shortly after leaving hospital. We found that the inadequate assessment was partly due to a number of poor systems in place at the Trust.

In relation to the handling of Mr N's complaint, the Acute Trust failed to adequately co-ordinate its responses with the Mental Health Trust. The Mental Health Trust failed to thoroughly investigate Mr N's complaint and failed to establish the facts of the case before responding.

We could not speculate as to what Mr Y's responses might have been had the Mental Health Trust asked the questions it should have. Therefore, we could not conclude that the Mental Health Trust's management plan (to discharge Mr Y) would have been any different, or that Mr Y would have followed any short term crisis advice. However, knowing that the assessment was inadequate caused Mr N and his family distress. This distress was compounded by inadequate complaint handling by both organisations.

Putting it right

The Mental Health Trust paid Mr N £1,000 compensation, and explained what it would do to prevent a recurrence of the service failings. The Mental Health Trust had already apologised to Mr N for its poor complaint handling before our involvement. We found that this was appropriate, but recommended that it take further action to improve its process for handling complaints.

The Acute Trust apologised to Mr N and paid him £250 to compensate for its poor complaint handling. It also drew up plans to improve its service and the co-ordination of joint responses to complaints.

Organisation(s) we investigated

Avon and Wiltshire Mental Health Partnership NHS Trust

Great Western Hospitals NHS Foundation Trust

Location

Swindon

Region

South West

Summary 842/February 2015

Poor nursing documentation in patient's records

Mr W complained about the care and treatment his late mother received while she was an inpatient at the Trust. He also said that his complaint was handled dismissively and not all the issues were addressed.

What happened

Mrs W was in her eighties and admitted to the Trust after having had a seizure at home. She was cared for in a side room because of her recent history of infections. Some two weeks after admission, she was transferred to a community hospital. Her condition deteriorated and she died soon after.

Mr W raised a number of concerns: his mother was left dehydrated; she suffered with infections acquired in the hospital; she was not appropriately tested for infections; and that general poor nursing contributed to her death.

What we found

We partly upheld this complaint. There was no evidence to support Mr W's assertions about poor care, or infections acquired in hospital.

But we agreed there were failings in respect of poorly completed nursing documentation, which meant that Mrs W's needs were not clear when she was transferred to another hospital. This raised concerns about the Trust's record keeping.

Mr W also made a complaint about information a doctor at the Trust gave him, but this had not been followed up, because the doctor concerned was on leave at the time of the local resolution.

Putting it right

The Trust created an action plan to address the identified failings around the record keeping. It also provided further information about the outstanding issue regarding a doctor who allegedly gave erroneous information to Mr W.

Organisation(s) we investigated

University Hospitals of North Midlands NHS Trust

Location

Staffordshire

Region

West Midlands

Summary 843/February 2015

Patient not given enough information before pain treatment, and an inadequate consent process

Miss L complained about a pain relief procedure. She was unhappy about the information she received, the consent process, the pain relief, and the needles used during the procedure which she said were bent due to the force used.

What happened

Miss L, who suffers from chronic regional pain syndrome (CRPS) in her lower right leg and foot, was under the care of a consultant at the Trust's pain clinic. Miss L had been given a number of different treatments to help her with her pain but had had little success, so in late summer 2013 the consultant decided to carry out percutaneous electrical nerve stimulation (PENS) procedure. This involves inserting a needle probe into the painful area and passing a low voltage electrical current through it, which can provide effective pain relief to some patients.

Miss L says that the procedure caused her a great deal of pain and distress and it subsequently made her condition worse.

What we found

We partly upheld this complaint. There was no evidence that the Trust gave Miss L appropriate information about the procedure and there was no consent form in her records. We could understand how not having appropriate knowledge of what to expect during the procedure may have made her experience more distressing than it would normally have been.

There were no failings in relation to Miss L's other concerns, and we concluded that her treatment was carried out appropriately and in line with established good practice.

Putting it right

The Trust apologised to Miss L and prepared an action plan to prevent the failings we found from happening again.

Organisation(s) we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 844/February 2015

Concerns around the support provided to a new mother after birth

Mrs B was distressed that the Trust failed to provide breast feeding support shortly after her baby's birth, and there were errors in her medical records.

What happened

Mrs B complained that the Trust failed to provide her with appropriate care and treatment during her admission to the maternity unit. In particular, she said she was not offered help to feed her baby that she believed caused his jaundice. She was also unhappy with the lack of skin-to-skin (mother and baby's skins touching) contact. She says staff insisted on feeding her baby with a small cup despite her requests to use a bottle. Staff later apologised for not explaining the reasons for this to her. Mrs B also complained that there were errors in her medical records which stated she had postnatal depression.

This affected what should have been a positive experience at the Trust, and Mrs B was worried about the lasting effect this may have on her baby. She said the Trust had not taken any steps to remedy the situation, and she would like financial compensation, an apology, and for the Trust to acknowledge its failings.

What we found

We partly upheld this complaint. The Trust had not taken steps to amend the inaccurate information it found in Mrs B's medical records. However, the Trust's response and apology in respect of Mrs B's care and treatment during her admission was enough to remedy the injustice caused.

Putting it right

The Trust added an amendment to the medical records, clearly stating that the entry in respect of her having postnatal depression was inaccurate. It also apologised for failing to do this earlier.

Organisation(s) we investigated

Barnet and Chase Farm Hospitals NHS Trust

Location

Greater London

Region

London

Summary 845/February 2015

Poor midwifery care meant woman delivered baby herself

Miss J says she should not have been discharged home from the maternity unit and although she delivered her baby safely at home herself, she did not receive appropriate midwifery care for the third stage of labour.

What happened

Miss J was pregnant for the first time, had irregular contractions and was admitted to the Trust's maternity unit late one night in winter 2012. Midwives sent her home just after midnight saying that she was not in established labour (4cm dilation with regular painful contractions).

Miss J's contractions continued and in mid-afternoon that same day she delivered a healthy baby at home before either the ambulance crew or midwife arrived. When the midwife came, she failed to explain the third stage of labour (what happens immediately after the birth) to Miss J and did not have the drug needed to make sure the placenta was delivered safely.

The midwife also did not make regular clinical observations or keep accurate and thorough records, so that when Miss J's condition started to deteriorate and she started to lose blood, she did not recognise that this was becoming an emergency. Miss J continued to lose blood and reported feeling unwell, but the midwife failed to take prompt action to make sure Miss J's condition did not get worse.

Eventually the midwife called an ambulance and Miss J was taken to hospital. When she arrived she was told her baby would be fed once she was settled. Miss J said that staff gave her confusing information about her baby's blood sugar level and the need for a drip.

She believed midwives failed to consider his low birth weight and so misdiagnosed his blood sugar level.

What we found

We partly upheld this complaint. Miss J had been rightly discharged from the maternity unit because she was not in established labour.

However, the midwife failed to explain the options for managing the third stage of labour, and did not recognise the need for giving Miss J the drug oxytocin. Overall, the midwife failed to plan her care, including delivering the placenta. She did not carry out thorough clinical observations, so that when an emergency situation arose she did not recognise it. There was also evidence of poor record keeping.

There was no evidence to support Miss J's view that the Trust overlooked her baby's birth weight when she was readmitted to hospital or that his blood sugar was misdiagnosed.

Putting it right

The Trust apologised to Miss J for the impact of the service failings we identified and paid her £700 in recognition of the suffering these failings caused.

The Trust explained the action it had taken to learn from these events, particularly in relation to communication and record keeping.

Organisation(s) we investigated

Colchester Hospital University NHS Foundation Trust

Location

Essex

Region

East

Summary 846/February 2015

Trust lost clinical records

Mrs T complained about her treatment in A&E but we could not investigate her complaint fully because the hospital had lost her clinical records.

What happened

Mrs T had a car accident and was taken to A&E by ambulance. She complained to us that she was left untreated on a trolley, her facial injuries were not treated properly, a radiographer treated her disrespectfully and she was discharged prematurely and without sufficient medical advice. She said that following her discharge she was left in considerable pain and unable to look after herself.

What we found

We partly upheld this complaint. The Trust had lost Mrs T's clinical records relating to her treatment in A&E. Because of this, our investigation was limited and we were unable to uphold any of her original complaints. We considered, however, that the loss of the records was an error in itself. This caused her injustice because she was not able to receive a conclusive independent investigation into her complaint.

Putting it right

The Trust apologised to Mrs T for the failings we found and paid her £150 in recognition of the fact that she was not able to have a full and independent investigation into her complaint.

Organisation(s) we investigated

Sherwood Forest Hospitals NHS Foundation Trust

Location

Nottingham

Region

East Midlands

Summary 847/February 2015

No fault in care and support of a mental health patient

Mrs A complained on her son's behalf about a lack of care and support provided by the community mental health team, and also about the team's lack of communication with the family.

What happened

Mr B was cared for in community supported living accommodation under the Care Programme Approach. His mental health deteriorated at times and he has to have help from various crisis teams and, at times, had been placed under sections 2 and 3 of the *Mental Health Act*. Mr B went to his family when he deteriorated and could be difficult to manage.

Mrs A complained to the Trust about a lack of help and support for him and the family. She said this lack of support had led to a decline in his mental health. She felt that her son should have had compulsory rehabilitation treatment and 24-hour supervision to make sure he was taking his medication. She also felt the care co-ordinator should have been more involved in providing help and support for them all.

What we found

We did not uphold the complaint. There was no evidence to support Mrs A's views that her son's care and treatment was poor and had led to a decline in his mental health. We saw instances where the care and support provided could have been better, but we did not consider that these amounted to failings in the service provided. Communication with the family was not as good as it should have been, which led to distress for the family in having to deal with Mr B. However, we did not find this was a failing, because discussions did take place, and the family were offered support. The Trust acknowledged that communication could have been better, and apologised for the effect this had on the family.

Organisation(s) we investigated

Lancashire Care NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 848/February 2015

NHS England addressed its complaint handling

We did not uphold Mr J's complaint about poor complaint handling because NHS England had taken remedial action before we became involved.

What happened

Mr J was a patient at GP Practice 1. He had concerns about his access to services, his medication, and the attitude of a GP. He also felt that the Practice had treated him differently because of his sexuality. Mr J then became a patient at GP Practice 2 and said they had prescribed him the wrong medication. He also had concerns about a GP's attitude.

Mr J complained to the NHS England Area Team about both Practices. The Area Team investigated Mr J's concerns and responded to him. Mr J then complained about how the Area Team had handled his complaint.

What we found

We did not uphold this complaint. The Area Team handled its investigation of the Practices reasonably, and ultimately provided Mr J with an appropriate report of its findings.

However, the Area Team's initial response to Mr J contained no analysis of its investigation into the GP Practices, and consequently it did not explain its decisions to him. It also did not report on some recommended remedial actions it had suggested.

There were some delays in the Area Team's response to Mr J's complaint which had resulted from a misunderstanding. It apologised for this and went on to make sure that it carried out subsequent responses promptly. We were satisfied with this action.

Putting it right

In the Area Team's final response to Mr J, there was a change to a more narrative style and there was an analysis of its investigation. This suggested that NHS England had adopted a more customer-focused approach. Our view was that this action pre-empted any recommendations we might have made to resolve our concern about a lack of explanation, and that as such the Area Team had already reasonably addressed this failing.

Organisation(s) we investigated

Birmingham, Solihull and the Black Country Area Team

Location

West Midlands

Region

West Midlands

Summary 849/February 2015

Ambulance crew were wrong not to take man to hospital, but correct in not giving him CPR

Ms G complained that an ambulance crew did not take her brother, Mr S, to hospital after he collapsed at home. Ms G also complained that at a later date another crew did not attempt resuscitation or defibrillation (an electric shock to the heart to help re-establish normal rhythms) when Mr S was found unresponsive on the floor.

What happened

Mr S collapsed at home and an ambulance was called. The crew decided not to take Mr S to hospital, and documented that they advised him to call 999 if it happened again, and that he should see his GP. Ms G spoke to an out-of- hours GP that night, who similarly advised her to call 999 if a further episode happened, but that otherwise Mr S should see his GP. Mr S saw his GP the following day and the doctor referred him to cardiology and neurology consultants. Staff did a number of tests but made no diagnosis.

Some months later, Ms G found her brother unresponsive on the floor. She called an ambulance and when it arrived, the crew confirmed Mr S had died. The crew did not perform CPR (chest compressions and mouth to mouth resuscitation), or defibrillation on him.

What we found

We partly upheld this complaint. There was a failing in that the crew did not refer Mr S to hospital; however, we did not consider that this had any detrimental effect on him. Mr S saw his GP the following day who also confirmed that it was not necessary to send Mr S to hospital, and referred him for appropriate specialist investigations. Therefore, it was highly unlikely that had Mr S been taken to hospital he would have had any better care. The Trust had already acknowledged the failing, apologised, and undertook learning to stop this happening again.

When an ambulance crew was called to Mr S some months later, our investigation found that the crew acted appropriately in their decision not to perform CPR or defibrillation. We did not uphold this part of the complaint.

Organisation(s) we investigated

South Central Ambulance Service NHS Foundation Trust

Location

Oxfordshire

Region

South East

Summary 850/February 2015

Wheelchair service made right decision in prescribing a class 2 powered wheelchair

Miss L complained that her local wheelchair service prescribed her a class 2 wheelchair when she had used a class 3 wheelchair for several years.

What happened

Miss L is an amputee and had used a wheelchair for many years. For seven years she had used a class 3 wheelchair which was able to travel on the road at up to eight miles per hour. The wheelchair was fitted with indicators and headlights as standard. In 2013 Miss L was re-assessed as her old wheelchair was becoming worn. The Clinical Commissioning Group's wheelchair service prescribed a class 2 wheelchair, which could only be used on the pavement and had a maximum speed of four miles per hour. As the wheelchair could not be used on the road it did not come fitted with indicators or headlights.

Miss L complained that her wheelchair was being downgraded and said that she needed a class 3 wheelchair because it had a longer range before needing to be recharged. The wheelchair service offered Miss L a voucher for the cost of the class 2 wheelchair which she could put towards the purchase of a higher specification wheelchair.

What we found

We did not uphold this complaint. The wheelchair service properly assessed Miss L's needs, and prescribed a class 2 wheelchair which met those needs. We noted that the range of the class 2 wheelchair exceeded the distance Miss L told us she regularly travelled. The wheelchair service made a reasonable offer of giving Miss L a voucher for the cost of the wheelchair it had prescribed.

Organisation(s) we investigated

South West Lincolnshire Clinical Commissioning Group (CCG)

Location

Lincolnshire

Region

East Midlands

Summary 851/February 2015

Getting it right for a patient in prison with long-term pain

Mr F, a prisoner, had been taking strong painkillers for a long-term health condition.

What happened

In early 2014, GPs at the Prison changed Mr F's prescriptions. Mr F was unhappy about the changes and made numerous complaints. Care UK, which provides most of the NHS healthcare at the Prison, responded to the complaints, so did Gables Medical Offender Health Ltd, which provides GP care to the prison. Mr F said that Care UK's responses were evasive. He also said there had been delays in him receiving some of his prescribed painkillers.

What we found

We partly upheld this complaint. The GPs' management of Mr F's medication reflected relevant guidance and established good practice. Their decisions about his medication were consistent with the symptoms they found when they examined him. They made appropriate arrangements to diagnose and treat him.

On two occasions, there were brief delays in giving Mr F his prescribed painkillers. Staff apologised for these delays and took action to resolve the situation. They also took steps to stop the problem from happening again. We found that was a reasonable way to put things right.

Overall, the responses to Mr F's complaints were reasonable. They addressed the concerns he raised and were not evasive.

Organisation(s) we investigated

Care UK

Gables Medical Offender Health Ltd

Location

County Durham

Region

North East

Summary 852/February 2015

Trust failed to check patient's medication, causing her to miss three doses

Mrs K's daughter complained that the Trust's care of her mother was poor, which caused her unnecessary worry.

What happened

Mrs K was admitted to the Trust in summer 2013 suffering from shortness of breath. Mrs K's daughter, Miss M, complained that the Trust failed to administer one of her mother's medications when she was admitted to hospital. Mrs K missed three doses which caused Miss M to worry.

Miss M also said that once its error had been recognised, the Trust reinstated the medication, but failed to monitor her mother sufficiently. Miss M also complained that the Trust failed to make sure that her mother had appropriate support when she was discharged, or make suitable transport arrangements when taking her mother home.

Miss M told us that as a result of the care at the Trust, her mother had an emergency admission to another hospital within 48 hours of discharge, and died of a heart attack within 24 hours of that admission.

What we found

We partly upheld this complaint because the Trust failed to properly follow its own policy for checking a patient's medication when they were admitted. This caused Mrs K to miss three doses. While this did not have a detrimental impact on her health, it caused worry to her daughter. The Trust's response to this aspect of the complaint was also contradictory and not based on the records, which caused Miss M further distress.

However, the Trust acted appropriately in reinstating Mrs K's medication when the error was spotted, and also in deciding to discharge her when it did. The Trust's response to Miss M's concern about her mother's transport home was reasonable.

Putting it right

The Trust apologised to Miss M for the distress caused to her, and prepared plans to make sure it adhered to its policy in future.

Organisation(s) we investigated

St George's University Hospitals Foundation Trust

Location

Greater London

Region

London

Summary 853/February 2015

Medical procedure unlikely to be responsible for ongoing ear, throat and eye symptoms

Mr S started experiencing problems with his ears, throat and one of his eyes after a gastroscopy procedure in summer 2013.

What happened

Mr S had a gastroscopy in summer 2013. This is a procedure where a thin, flexible tube called an endoscope is used to look inside the stomach. Doctors found nothing untoward, and Mr S's consultant prescribed him medication to treat acid reflux (when stomach acid moves up into the gullet) and discharged him.

Mr S complained to the Trust in spring 2014 that he had had ongoing ear, nose and throat symptoms which started around the time he had the gastroscopy. He was concerned that they were linked and he raised particular concerns about the way the procedure was carried out.

The Trust explained the procedure and the equipment used.

It also responded to Mr S's concerns and said there was no evidence in the records of any problems during the gastroscopy. It said the procedure can cause short term symptoms such as a sore throat, but there was no evidence it had caused the long term problems Mr S had described.

Mr S was unhappy with the Trust's response and contacted us.

What we found

We did not uphold the complaint. There was no evidence of poor care by the Trust and the records were of good quality. The procedure was well documented and we saw no evidence in the records of any problems or of anything going wrong. The records showed that the procedure was straightforward and went smoothly. The Trust provided reasonable explanations in response to Mr S's concerns.

Gastroscopy procedures can cause short-lived symptoms such as mild soreness of the throat, but they do not cause long-term symptoms. We concluded that, on the balance of probabilities, Mr S's ongoing problems were not linked to the gastroscopy.

Organisation(s) we investigated

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Location

Lincolnshire

Region

East Midlands

Summary 854/February 2015

Correct fine for patient when his medical exemption certificate expired

Mr B felt that he had been penalised because of NHS Business Services Authority's lack of communication with other NHS organisations over renewing his certificate which entitled him to free prescriptions.

What happened

Mr B claimed exemption from paying for a prescription, believing he had a valid medical exemption certificate. However, his certificate had expired but Mr B was unaware of this. The Authority had previously written to Mr B to advise him of a change in process, and to remind him to renew his certificate. Mr B did not receive the letters, as he had changed address.

Mr B had updated his records with his local hospital, his GP, and his diabetes clinic, and assumed his records would be updated throughout the NHS.

What we found

We did not uphold this complaint. The prescription form clearly shows it is the patient's responsibility to make sure they complete it accurately. Mr B signed a statement agreeing to 'appropriate action' if it was found he had claimed prescription charges without having an exemption certificate. The exemption certificate itself contained a valid from and expiry date.

The NHS Business Services Authority made reasonable efforts to contact Mr B, and although he qualified for exemption, he did not have a valid certificate when he made his claim for exemption from his prescription charge.

Organisation(s) we investigated

NHS Business Services Authority

Location

Essex

Region

East

Summary 855/February 2015

Patient transferred from acute hospital without adequate assessment

Mrs S's daughter complained that her mother should not have been transferred from an acute to a community hospital.

What happened

Mrs S was in her nineties and fell at home. She was admitted to the Acute Trust. Doctors assessed her and decided to transfer her to a nurse led community hospital (part of a different trust).

While she was there she had another fall and had to be readmitted to the Acute Trust. She was found to have a large and incurable subdural haematoma (a serious brain condition that is caused when blood collects between the skull and the surface of the brain) and she died a few days later.

Mrs S's daughter, Mrs T, said her mother's care and treatment at both hospitals was inadequate and that doctors at the Acute Trust inappropriately transferred her mother to the Community Hospital.

What we found

Doctors at the Acute Trust did not adequately assess Mrs S or give sufficient consideration to arranging further medical care for her before transferring her to the Community Hospital. We also found the handover to the Community Hospital was inadequate. Care that nurses at the Community Hospital gave to Mrs S fell below the relevant standards.

We were unable to say whether the outcome for Mrs S would have been any different if the failings we had found had not happened. But opportunities to provide further medical care were missed. Mrs T will never know whether her mother would have survived if she had received the care and treatment she should have. The not knowing, together with distress stemming from the poor way her complaints were handled by the acute Trust, were injustices to her.

Putting it right

Both Trusts acknowledged their failings and apologised. The Community Trust had already demonstrated that it had learnt from the complaint. However, at our request the acute Trust completed an action plan to demonstrate what it had done to avoid a recurrence of the failings.

Organisation(s) we investigated

Royal Devon and Exeter NHS Foundation Trust (the Acute Trust)

Northern Devon Healthcare NHS Trust (the Community Trust)

Location

Devon

Region

South West

Summary 856/February 2015

GP correct to visit patient about her mental health

Mrs A complained that her GP visited her without consent. She said that the GP told her she was making the visit to consult her about her symptoms of thrush, but had actually visited to make a mental health assessment.

What happened

Mrs A, who had a history of bi-polar illness, went to her GP Practice because of symptoms of thrush. Her GP was unable to see her immediately but agreed to visit her at home later the same day. Earlier that day, Mrs A's son and a friend had both raised concerns with the Practice about Mrs A's mental health. The GP visited Mrs A at home and felt that Mrs A was showing signs of a recurrence of previous mental health problems. Mrs A had been on medication for this but had stopped because she felt she did not need it.

Mrs A felt that instead of the visit being for the purpose of treating her thrush, the real purpose was to carry out a mental health assessment, and this was without her consent.

The GP said that she was justified in asking Mrs A about her mental health because Mrs A's son and a friend had expressed concerns about Mrs A's behaviour and mental health. Also, Mrs A had a past history of bi-polar illness.

What we found

We did not uphold this complaint. The GP visited Mrs A with her consent and in her best interests. Mrs A's son and a friend had drawn the GP's attention to behaviour which was symptomatic of manic behaviour typical in bi-polar illness, and it was therefore appropriate for her to take these concerns into account when seeing Mrs A. She obtained Mrs A's consent for a home visit, during which Mrs A displayed symptoms that were consistent with a recurrence of her bi-polar illness.

According to the General Medical Council guidance, information from a patient's partner, carers or others may be used to help doctors decide how to care for their patient. There were no failings on the part of the GP who in our view gave Mrs A appropriate care in accordance with national guidance.

Organisation(s) we investigated

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 857/February 2015

Trust made an error when booking a follow up appointment for patient

Mrs C was not happy with Trust's advice after she had had treatment to her foot, so she went for a private second opinion. The private doctor told her that the Trust's advice was incorrect and had she followed it she would have permanently lost the use of her ankle.

What happened

Mrs C fractured her ankle after an accident and had treatment at the Trust. She said that staff advised her to put her leg up and rest it, and gave her a follow up appointment in two months. Mrs C received a letter to confirm this. Mrs C was distressed by this, so went to a private doctor for a second opinion. The private doctor told her that she should only rest her foot for two weeks, and if she had followed the Trust's advice she would have permanently lost the use of her ankle. She paid £323.50 for this advice.

Mrs C contacted the Trust and it told her that she should have had a follow up appointment two weeks after her initial consultation, but due to human error the appointment was actually made for two months' time. The Trust said this was later corrected in a letter to Mrs C's GP.

The Trust apologised to Mrs C for the misunderstanding but explained that it had written to her GP and corrected the time of the appointment. It said it would have expected Mrs C or her GP to contact the Trust if they had any concerns over the follow up care or advice the consultant gave Mrs C. The Trust did not agree to reimburse Mrs C's costs so she came to us.

What we found

The Trust made an error when booking Mrs C's follow up consultation. As a result of this Mrs C was distressed and sought a second opinion which she paid for privately. If the Trust had given Mrs C an appointment in two weeks' time she would not have sought and paid for a second opinion. While the Trust acknowledged the error and apologised for this, it did not put right the injustice Mrs C suffered as it declined to reimburse the costs of her private consultation.

Putting it right

The Trust had already acknowledged the error and apologised to Mrs C. It agreed to improve its service by copying all clinic letters to patients in the future. The Trust reimbursed Mrs C £323.50 for the cost of the private appointment.

Organisation(s) we investigated

Milton Keynes Hospital NHS Foundation Trust

Location

Milton Keynes

Region

South East

Summary 858/February 2015

Failings in the care of an older patient did not lead to her death

Mrs F complained about the care and treatment the Trust provided for her late mother. She said doctors contributed to her mother's death, causing her family distress and grief.

What happened

Mrs J, who had dementia, was admitted to hospital via A&E on the advice of an out of hours doctor because of concerns about her heart rhythm. While in hospital Mrs J had a stroke. She was transferred to the stroke unit but continued to deteriorate, and died in hospital three weeks after being admitted.

Mrs F complained that ward staff did not notice her mother had had a stroke. She also was unhappy about how the medical team managed her mother, about a number of nursing issues, and about poor communication. When the Trust responded to Mrs F's complaint, its responses were incomplete and were not sent by the chief executive. Mrs F told us she was shocked by the tone of the responses.

What we found

We partly upheld this complaint. Although the doctors took appropriate steps to identify the cause of Mrs J's symptoms and gave her suitable treatment, they did not monitor her condition as closely as they should have done. Also we saw that although Mrs J's stroke was probably related to the problem with her heart rhythm, there was nothing further that could have been done to prevent her having a stroke.

There were failings in hygiene; the attitude of nursing staff; communication with the family; awareness of dementia; the time taken to diagnose Mrs J's stroke; monitoring by nursing staff; and the Trust's complaint handling. Although the Trust had already acknowledged failings in Mrs J's care, apologised and taken some action to address this, we concluded it had not gone far enough.

We found no failings in Mrs J's end of life care, and no evidence her death could have been prevented if these failings had not happened.

Putting it right

The Trust expanded on the work it had already done in order to improve its services and apologised to Mrs F.

Organisation(s) we investigated

North Cumbria University Hospitals NHS Trust

Location

Cumbria

Region

North West

Summary 859/February 2015

Patient's concerns about discrimination

Mr B was concerned that a surgeon did not want to operate on him because he was HIV positive and transferred him to another hospital to have the operation.

What happened

Mr B's GP referred him to an NHS Treatment Centre run by Care UK for investigation and treatment of his sinusitis (an infection of the sinuses). Mr B had recently been diagnosed as HIV positive. Doctors arranged an operation for him but the surgeon told Mr B that the surgery would not go ahead at the Treatment Centre but that he would refer him to another hospital. The surgeon said this was in case of complications, but Mr B thought that he was transferring his care as he did not want to treat him because of his HIV positive status. Mr B felt he was discriminated against.

What we found

We did not uphold the complaint as the Treatment Centre had accepted its shortcomings and taken action to prevent the same thing happening again.

There were clinical reasons for transferring Mr B as he had a high risk of serious complications. The surgeon had discussed the case with his colleagues, and they felt that it was in Mr B's best interest to have surgery where there was access to a full range of equipment and multidisciplinary teams. The Treatment Centre was only able to deal with straightforward low risk surgery and did not have access to specialist teams or equipment.

The surgeon did not communicate the reasons for the transfer very well, which led Mr B to believe that he was transferring him because he was HIV positive. There were shortcomings in the surgeon's communication with the patient, which the Treatment Centre and the surgeon acknowledged. The surgeon said he had undergone training to improve his communication skills, and told us that he was very sorry for the distress caused to Mr B.

Organisation(s) we investigated

Care UK

Location

Bristol

Region

South West

Summary 860/February 2015

Delay in starting investigation into GP practice

Mrs M asked NHS England to investigate her concerns about the death of her husband, who died the day after seeing his GP.

What happened

Mr M contacted the Practice in summer 2013 as he had been suffering from hiccups for four days and had mild diarrhoea. The GP called him back and booked Mr M in for an emergency appointment that afternoon. At the appointment, the GP examined Mr M and noted that he had a reflux like pain (reflux is when acid produced in the stomach passes into the gullet) which seemed to be eased by food, and that his chest was clear. He prescribed Mr M lansoprazole to treat the reflux, and referred him for a non-urgent chest X-ray. Mr M died the following day.

Mrs M complained to NHS England in winter 2013 about the treatment her husband received. NHS England did not start the investigation until early 2014, and sent the final response to her in spring 2014

What we found

We partly upheld this complaint. We decided that the Practice did not misdiagnose Mr M, as his diagnosis was made in line with current guidance. We could see that the treatment plan, and the advice to return to the Practice if his symptoms worsened, were in line with the National Institute for Health and Care Excellence guidance. There was nothing to indicate that this guidance should not have been followed.

NHS England's investigation was thorough and consistent with the facts. But there were no reasonable explanations for the delay by NHS England in starting the investigation, and it failed to keep Mrs M informed about the reasons for the delay.

Putting it right

NHS England apologised to Mrs M for the way it handled her complaint and paid her £200 compensation for the additional distress this caused. It also explained how it planned to improve its complaint handling.

Organisation(s) we investigated

A GP practice

NHS England

Location

West Midlands

Region

West Midlands

Summary 861/February 2015

Pharmacy prescribed incorrect medication to patient

Ms B complained that she was given another patient's medication when she collected her prescription from the Pharmacy. She took the medication for two weeks and fell ill.

What happened

Ms B's GP prescribed her a particular medication to treat her sore leg. When she went to the Pharmacy to pick it up, staff gave her another patient's antidepressant medication.

Not knowing she had been given the wrong medication she started the course and became ill with dizzy spells for two weeks. She saw her GP who realised that she had been given the wrong medication.

Ms B complained to the Pharmacy but it had already acknowledged that mistakes had been made. It had already apologised to Ms B and gave assurances that service improvements had been made to make sure that a similar incident did not occur in future. However, it was not willing to comply with Ms B's request for £250 compensation.

What we found

We partly upheld this complaint. The Pharmacy had already acknowledged its failings and we were satisfied with the Pharmacy's apologies and service improvements. However, we agreed with Ms B that it should pay her compensation in recognition of the effect the medication had on her.

Putting it right

The Pharmacy paid Ms B £250 compensation.

Organisation(s) we investigated

Tesco Pharmacy

Location

Merseyside

Region

North West

Summary 862/February 2015

Opportunities missed to improve patient's chances of survival

Failings in Mrs C's care meant she missed opportunities for further treatment and she could have been made more comfortable in her last few weeks.

What happened

Mrs C, in her nineties, was admitted to hospital in winter 2011. Doctors diagnosed her with an infection and gave her a course of antibiotics. Staff attempted to discharge her near the end of the year but eventually she remained in hospital for another two weeks over the Christmas period. She deteriorated during this time and doctors believed she had developed sepsis. They gave her a different course of antibiotics for this but stopped the treatment when they saw the medication was not appropriate for her. Shortly afterwards, doctors decided to stop treating her as they believed she was near the end of her life and treatment would not have any benefit. Around the same time, she moved ward. Doctors then decided to start treating her again as they considered treatment may still have some benefit for her. However, Mrs C died shortly afterwards.

Mrs C's granddaughter complained that the care Mrs C received was inadequate, and she believed that reduced staffing levels over the Christmas holidays were responsible for this. She said there were delays in tests being completed; periods of time when her grandmother was not given antibiotics; a delay in providing treatment for suspected sepsis; a lack of review by doctors; and delays in handling her complaint about this. She said this caused her grandmother and the wider family distress.

What we found

We partly upheld this complaint. We did not find failings in Mrs C's initial assessment and treatment when she first went into hospital. However, we did find failings in the staff's understanding of Mrs C's condition, and therefore her care and treatment during her admission. There were delays in tests being completed, periods of time where she was not given antibiotics, a delay in giving her treatment for suspected sepsis, a lack of review by doctors, and delays in handling her granddaughter's complaint.

While we did not believe that appropriate care would have prevented Mrs C's death, opportunities were missed to improve her chances of survival and to make her more comfortable.

Putting it right

The Trust apologised to Mrs C's family for the distress caused by the missed opportunities to improve her care and her reduced chances of survival. It also completed a clinical review of care to identify improvements to prevent this happening again. It also paid £1,500 compensation to Mrs C's family for the additional distress caused to them and to Mrs C.

Organisation(s) we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 863/February 2015

Patient not told that 'stop smoking' medication could be detrimental to his mental health

Mr A complained that his GP did not take his mental health condition properly into account when he prescribed Champix to help him stop smoking.

What happened

Mr A, who was in his twenties, had a long standing history of schizophrenia. He went to see his GP about prescribing medication to help him stop smoking and the GP prescribed Champix. Mr A took the Champix and suffered a relapse of his schizophrenia. He had to spend three months in hospital.

Mr A complained to the Practice. The Practice said the GP had considered his psychiatric history when he prescribed Champix. The GP said that when Mr A's mother contacted him to say Mr A had become unwell, he advised her that Mr A should cease taking Champix. The GP was sorry to think that something he had done had caused harm.

What we found

We partly upheld this case. The GP failed to act in accordance with the relevant clinical and record keeping guidance when he prescribed Champix to Mr A. General Medical Council prescribing guidance required that the GP should have told Mr A about the risks of taking Champix as he had a history of psychiatric illness. The GP said that he had made Mr A aware of the risks, but this was not supported by the notes he took at the time. We also noted that there was no monitoring plan in place and Mr A had not been advised to stop taking Champix if he started to feel unwell.

It was possible that Mr A's relapse could have been linked to using Champix; however, it was impossible to say conclusively that Champix was the direct cause.

While we cannot be certain that Mr A suffered a relapse of schizophrenia as a result of taking Champix, we did find that he suffered an injustice. Mr A was denied the opportunity to make an informed choice about whether to take Champix because we could find no evidence that he was warned of the side effects, or told what to do if he became unwell.

Putting it right

The GP acknowledged and apologised for his failings and paid Mr A compensation of £500.

Organisation(s) we investigated

A GP practice

Location

North Yorkshire

Region

Yorkshire and the Humber

Summary 864/February 2015

Complaint about early discharge not upheld

Mrs B had serious complications following abdominal surgery. She complained that this was caused by failings of the Trust.

What happened

Mrs B was discharged four days after surgery and had to be admitted a few days later as an emergency. She stayed in hospital for almost two months as she had a series of serious complications and infections which left her with long term health problems. She complained that the Trust contributed to these complications by discharging her too soon after surgery and not providing her with adequate care. She said when she was readmitted as an emergency the Trust took too long to deal with the complications effectively. She also complained about some elements of the nursing care.

What we found

We did not uphold this complaint. There were some problems with the way Mrs B was discharged, but these did not cause or contribute to the subsequent complications. Mrs B was very unlucky to have all the complications that she did, but they are all accepted complications after the surgery and were not the fault of the Trust. The complications were managed and treated as they should have been when Mrs B was readmitted, and there were no delays with this.

We did not find that the evidence substantiated Mrs B's complaints about the nursing care, but we noted that one of these issues had not been investigated properly by the Trust. However, the complaint handling was reasonable overall.

Organisation(s) we investigated

Derby Hospitals NHS Foundation Trust

Location

Derby

Region

East Midlands

Summary 865/February 2015

Complaint about antibiotic treatment, a care plan and hospital accommodation

Mrs N complained that her husband did not receive adequate care and treatment when he went into hospital and this delayed his recovery.

What happened

Mr N went into hospital for treatment of cellulitis, a skin infection. Mrs N was unhappy about the antibiotics the Trust prescribed for him and said there was no defined care plan for elevating his leg. She said he had to stay for longer than was ideal in an inappropriate waiting area.

The Trust said that doctors prescribed antibiotics that were suitable for Mr N's condition. It pointed out that his leg was elevated at times and he had also spent time moving about as part of his therapy programme. It insisted that he had a clear plan of treatment relevant to his condition. It acknowledged that Mr N had stayed for longer in the waiting area than was ideal and conceded that this area lacked patient comforts. It apologised for this and took steps to improve the situation.

What we found

We did not uphold this complaint. Our clinical adviser agreed that the antibiotics prescribed for Mr N's husband were correct. Although the plan for elevating his leg could have been more defined, his treatment was not unreasonable and a more specific regime would not have made any difference to his recovery. We noted the Trust's acknowledgement that the escalation area facilities and processes were not ideal, and we confirmed that it had indeed made the planned improvements it had told Mrs N about.

Organisation(s) we investigated

Peterborough and Stamford Hospitals NHS Foundation Trust

Location

Peterborough

Region

East

Summary 866/February 2015

Appropriate care was provided by a GP Practice but administration failings led to distress

Ms A and Ms B complained about the care their GP provided, and that they were unfairly removed from the Practice list.

What happened

Ms A, and her mother Ms B, were newly registered patients at their GP Practice. Ms B had long-term sight and balance problems and she went with her daughter to her new GP. The GP agreed to refer Ms B to a neurologist, however, the referral was delayed as the GP had not received Ms B's records from her previous practice. Ms A complained about this and also the consultation with the GP, and told the Practice that she had accidentally recorded the consultation on a recording machine she had with her at the time. The Practice felt this breached the doctor/patient relationship and removed Ms A and Ms B from its practice list.

What we found

We partly upheld this complaint. The GP had carried out an appropriate and reasonable consultation and correctly decided to refer Ms B to a neurologist. It was also reasonable for the GP to wait until he had received Ms B's previous records before referring her. However, the GP could have been clearer in managing Ms A's and Ms B's expectations about when he would send the referral, but on balance, this was not a failing. Also, although the GP had written a correct prescription for Ms B in an earlier consultation, he had not appropriately recorded his reasoning for this. This was a failing.

The Practice did not follow the steps set out in its contract for removing patients from its Practice list. This is because it had not given Ms A and Ms B a warning to tell them that they were at risk of being removed from the list. This was a failing. We found that these failings caused Ms A and Ms B distress.

Putting it right

The Practice apologised to Ms A and Ms B for the distress caused. It also put in place an action plan to reduce the likelihood of a similar situation happening with other patients.

Organisation(s) we investigated

A GP practice

Location

Greater London

Region

London

Summary 867/February 2015

No failings in the care and support provided to a mental health patient and her carer

Mr Q complained the Council and Trust failed to provide support to his partner, Ms J, or to support him as a carer. He said the Council did not deal with his complaint within a reasonable time and both the Council and the Trust caused him and Ms J avoidable stress and anxiety.

What happened

Mr Q is Ms J's carer. Ms J has a diagnosis of schizophrenia and has psychotic symptoms such as auditory hallucinations and paranoid delusions. She first had contact with the Trust because of her psychotic symptoms in 1999. Mr Q has been involved in Ms J's care for over a decade and they live together.

In late 2013 Mr Q complained to the Council that he did not consider the Crisis Team provided adequate support when Ms Q's mental health deteriorated out-of-hours. He thought a qualified mental health professional should be available at any time to assess Ms J and 'take responsibility' until her behaviour was stable. In addition, Mr Q said he did not feel the Council provided adequate support for him in his role as carer.

The Council responded in spring 2014 and included information obtained from the Trust. They did not identify any significant failings in the care they had provided to Ms J or in the support they had provided to Mr Q.

What we found

We did not uphold this case, which we investigated jointly with the Local Government Ombudsman. We were satisfied the Council and Trust both provided a service in line with relevant policies and guidance. There was no evidence of fault in the care that they had provided to Ms J, or in the support they gave to Mr Q. There was a delay in responding to the complaint, but there was no injustice to Mr Q and Ms J as they had access to services throughout.

Organisation(s) we investigated

Lancashire Care NHS Foundation Trust

Lancashire County Council (investigated by the Local Government Ombudsman)

Location

Lancashire

Region

North West

Summary 868/February 2015

Care home failed to dress a resident's wounds properly

Mrs B was a resident at a care home. She had leg wounds which were not dressed properly. The care home's investigation failed to acknowledge this.

What happened

Mrs B was resident at a private care home and funded by the NHS. She had to go to hospital, and on admission, a nurse noted that her leg ulcers had not been dressed properly. Mrs B's daughter, Mrs S, complained to the home about this, but was not happy with the response and so she complained to us. Mrs S said that the home's failing may have contributed to her mother contracting an infection, and that her health deteriorated further after being in hospital. Mrs S said that her efforts to find out the truth were very stressful.

What we found

Many aspects of the home's care of Mrs B's leg wounds were good. However, there was insufficient detail in the records to suggest it had formally assessed her wounds on a regular basis. On at least one occasion, the dressings were applied incorrectly and there was evidence for this in the hospital records. We realised that this was possibly an isolated incident, but it was not appropriately investigated by the care home manager, so there was no explanation of why or how it happened.

We did not find that the home's management of Mrs B's wounds caused her to go to hospital.

Putting it right

We saw no evidence of widespread failings in wound management at the home, and so we made no recommendations to improve its service. The care home manager agreed to apologise to Mrs B's daughter for the issues we had identified.

Organisation(s) we investigated

A care home

Location

Lancashire

Region

North West

Summary 869/February 2015

Trust delayed properly investigating facial pain for twelve years

Ms L suffered from facial pain which went undiagnosed and untreated for twelve years despite her repeatedly seeking help from the Trust during that time.

What happened

Ms L first went to the Trust in 1997 because she had severe and unrelenting facial pain. She attended appointments many times between 1997 and 2012. During that time, the Trust treated her pain conservatively, but despite Ms L repeatedly asking for an MRI scan, staff did not arrange this until she insisted on it in 2012.

The MRI scan diagnosed the cause of her facial pain and doctors then referred her for treatment. She had surgery that resolved the pain. Until this time, the pain affected Ms L's quality of life and her ability to manage everyday tasks.

What we found

The Trust acted unreasonably in not seeking an MRI scan earlier. While initially the clinical indications were for conservative treatment, staff should have carried out an MRI scan in 2000.

Twelve further years was an unreasonably long period of time not to have arranged an MRI scan so that staff could try to diagnose the unresolved pain. This contributed to Ms L's unnecessary suffering during that period.

Putting it right

The Trust apologised for the delay and wrote to Ms L to explain what action it had taken to remedy this for future patients. It also paid her £750 in recognition of the pain and distress the delay caused.

Organisation(s) we investigated

Isle of Wight NHS Trust

Location

Isle of Wight

Region

South East

Summary 870/February 2015

Patient said that she did not receive appropriate care and treatment to remove contraceptive implant

Miss A was unhappy with the care and treatment she had received from her GP to remove her contraceptive implant. Miss A was distressed by the experience and she did not want to return to the Practice.

What happened

Miss A asked the GP to remove a contraceptive implant because of her weight gain and irregular bleeding. She went to a double appointment (20 minutes) to have the implant removed from her arm. At that appointment the GP tried unsuccessfully to remove the implant. She tried again and made a further incision in Miss A's arm using additional anaesthetic, but this was also unsuccessful. The unsuccessful procedures caused some bruising and swelling to Miss A's arm. The GP applied Steristrips to the wound and made a further appointment for Miss A to return when the bruising and swelling had settled.

Miss A said the GP had not allowed enough time for the appointment. She said the procedure left her with unnecessary swelling and scars, and that the Steristrips and dressings used on the wound caused an allergic reaction.

What we found

We did not uphold this complaint. The GP acted reasonably in allocating 20 minutes for the procedure. Practice records showed that Miss A had been counselled about the procedure and that she was warned of the risks of scarring beforehand. Records also show that Miss A gave consent for the procedure. The GP acted appropriately in giving an additional anaesthetic injection in an area not covered by the first.

The same dressing had been used at the time of the Miss A's original implant and there was nothing to suggest that Ms A had had a reaction to it at that time.

The Practice accepted that it would be helpful to develop new leaflets with more information about Steristrips, and invited Miss A to contribute towards the content.

Organisation(s) we investigated

A GP practice

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 871/February 2015

Scan results not passed to patient for many months because of inadequate appointment system

Ms C had to wait for a diagnosis because of GP practice's poor system for making appointments and communicating test results.

What happened

Ms C had a CT scan in summer 2013. Staff sent the results to the Practice the next month. Unfortunately the GP Practice did not tell Ms C they had arrived and there were conflicting accounts about what happened. The Practice alleges that an appointment was made to see her, but Ms C said she was on holiday at the time that the appointment was arranged, and so could not have agreed to it.

As a result of this, Ms C was not told that she had polycystic ovaries (a condition that affects the ovaries) until she went to an appointment in spring 2014. She queried why she had not had the results. She was then offered treatment or a referral to secondary care, but she decided that she had lost faith in the Practice and changed to another GP.

What we found

We partly upheld this complaint. The Practice's version of events was unable to be substantiated due to a lack of evidence. We saw that the systems in place did not provide an adequate safety-net to prevent this happening, and that the diagnosis should have been communicated to Ms C.

However, we did not see that the delay in this case had resulted in an injustice to Ms C, as she was asymptomatic during the six months and the delay in beginning treatment had no effect on her health.

We also found that the GP who she saw in spring 2014 acted appropriately upon discovering the scan result.

Putting it right

The Practice apologised to Ms C for the impact that the failings had on her. It also prepared an action plan to show how it would improve its system regarding the receipt of test results to minimise the risk of this happening to future patients.

Organisation(s) we investigated

A GP practice

Location

Essex

Region

East

Summary 872/February 2015

Dental practice tried to address patient's problems

When Mr D had problems with a number of crowns and his denture, the Practice tried to put things right, which included giving him some treatment free of charge.

What happened

Mr D's front crown fell out and the Practice tried to refit it but this failed. It added a false tooth to his denture as an alternative. Mr D then lost two further crowns and the dentist replaced the existing denture with a new denture. Mr D complained that the dentist performed the initial treatment incorrectly and this led to all the subsequent problems he experienced. He was also unhappy with the new denture supplied.

What we found

We did not uphold this complaint. The Practice did not cause the problems Mr D experienced and did everything it reasonably could to try to improve the situation for him. The crowns had been in place for several years and we considered this was the most likely explanation for them failing.

Organisation(s) we investigated

A dental practice

Location

East Sussex

Region

South East

Summary 873/February 2015

GP Practice took appropriate action when following its zero tolerance policy

Mr C complained that he was unfairly removed from his GP's patient list.

What happened

Mr C went to his GP Practice and was upset to find that the GP he was meant to see was on sick leave. He refused to see a different GP and demanded to speak to the manager. The manager and a colleague had a long meeting to discuss Mr C's concerns. They claim that during the meeting, Mr C became verbally abusive and they ended the meeting. Mr C then raised his hand in the manager's face, which led to staff calling the police. Mr C was later removed from the Practice's patient list and registered with a different practice under the local NHS zero tolerance scheme.

What we found

We did not uphold the complaint. The Practice followed its own policy and acted in line with the relevant regulations.

Organisation(s) we investigated

A GP practice

Location

West Midlands

Region

West Midlands

Summary 874/February 2015

Hospital failed to refer patient with rare cancer to a specialist team

Mr K complained that the Trust did not refer his wife, Mrs K, who had a rare cancer, to an appropriate specialist team. He said that the hospital failed to follow relevant clinical guidelines and made poor decisions about his wife's care.

What happened

Mrs K was diagnosed with a sarcoma, a rare type of cancer, in early summer 2011. The consultant oncologist in charge of her care started radiotherapy treatment. He did not seek any specialist advice about what treatment Mrs K should have. In early autumn 2011 Mrs K was discharged from the oncology department and staff told her she would have follow-up appointments at a different department.

In early 2012 Mrs K started to experience leg pain and loss of feeling in her buttocks. A scan showed she had a cancerous tumour on her lower spine. She had surgery to remove the tumour, although it could not be completely removed, and she also had radiotherapy.

The next month, Mrs K asked to be referred to a specialist cancer hospital, but she was told she would be referred to the sarcoma multidisciplinary team at a different specialist centre in another area. Mrs K asked again to be referred to the specialist cancer hospital, and told the hospital she had found out she should have been referred to a specialist sarcoma centre when she was first diagnosed with a sarcoma.

In spring 2012 Mrs K had a scan that showed the cancer had spread to her lungs and possibly her liver. Mrs K was referred to the specialist cancer hospital and had the rest of her treatment there. She died in summer 2013.

What we found

We partly upheld this complaint. The Trust should have sought specialist advice from a sarcoma multidisciplinary team about Mrs K's treatment when her cancer was first diagnosed. This would also have given Mrs K access to a sarcoma key worker (nurse) and her family would have been able to discuss in more detail the implications of her diagnosis and the outlook for her. The opportunity to explore options for any sarcoma-specific clinical trials was lost. Trust staff misjudged the severity of Mrs K's cancer at first, but this did not affect the treatment she received.

There are variations in clinical practice about whether to give radiotherapy in cases of this type of sarcoma. We could not say that the decision to give radiotherapy in Mrs K's case was a failing in her care. There was no evidence to suggest Mrs K would have received chemotherapy if she had been referred to a sarcoma multidisciplinary team.

There was no evidence that Mrs K was given the option of being referred to a specialist cancer hospital. She was also not given a written care plan.

Putting it right

The Trust apologised to Mr K for the faults in his wife's care and paid him £1,000 compensation to recognise the unnecessary distress caused to him, his wife and family by the failings. It also produced an action plan describing what it had done to make sure it learnt lessons from the faults we had identified.

Organisation(s) we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Location

Blackpool

Region

North West

Summary 875/February 2015

Nursing staff acted reasonably in changing patient's oxygen intake and reassessing his intravenous fluid intake

Mrs Y complained that the Trust did not manage her late husband, Mr Y's, oxygen intake appropriately on the night before he died and that staff did not give him additional intravenous fluids in a timely manner. Mrs Y told us that this meant he became restless and he suffered as a result.

What happened

Mr Y was admitted to an acute medical ward with pneumonia, sepsis and Alzheimer's disease. At the time, he was so poorly that it was agreed with family that he would not be resuscitated if the need arose. Staff treated him with oxygen and intravenous fluids.

Mrs Y said that her husband was responding to the oxygen that he was receiving, however, the staff nurse changed this and this made him restless. She also stated that his intravenous fluids ran out and that she had to ask nursing staff a number of times to give him further fluids before they did so.

What we found

We did not uphold this complaint. The staff nurse behaved reasonably throughout. She changed the oxygen mix and implemented mouth care to increase Mr Y's oxygen saturation levels and make him more comfortable.

The nurse also liaised with a doctor to establish whether further intravenous fluids would be required and if so, at what rate. The nurse should have recorded this consultation with the doctor in the medical records but she did not. That said, she gave a verbal handover to a nurse starting the next shift and the fluids were given shortly after.

Organisation(s) we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 876/February 2015

Delay in telling cyclist about broken bone

Mr J fell off his bicycle and injured his head. He was taken to the Trust's hospital for emergency treatment.

What happened

A doctor in the Trust's emergency department arranged an X-ray. He thought Mr J had injured some muscles in his neck, and sent him home. Mr J was still in pain, so he went back to hospital a few days later. Doctors examined him again and found he had broken bones in his back. They gave him a brace to wear, and he went to the Trust for further treatment. He had more scans, which showed that his fracture was healing well. One scan showed that he also had a broken bone in his neck. The Trust told Mr J about this at an appointment some three weeks after the scan. Mr J was unhappy about his treatment and complained to us.

What we found

We partly upheld this complaint. Mr J's fracture was difficult to see on the original X-ray, but the Trust had appropriate systems in place to review the X-ray and recall Mr J. In the event, he came back to hospital before staff had a chance to recall him. Overall, the care Mr J received in the emergency department reflected established good practice.

Although it was appropriate for the Trust to arrange an appointment to tell Mr J the result of his scan, three weeks was too long to wait to tell him he had another broken bone. The fracture was stable and did not need active treatment, so there was no danger that Mr J could have suffered physical harm as a result of not knowing about it. But he was clearly upset that the Trust had not told him about this broken bone.

Putting it right

The Trust apologised to Mr J for the distress he experienced.

Organisation(s) we investigated

Lancashire Teaching Hospitals NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 877/February 2015

Consultant cardiologist appropriately stopped patient's medication after a heart operation

Mrs T complained that the consultant cardiologist took her off medication she had been prescribed after an operation to replace a valve in her heart, and this caused her to have a stroke.

What happened

In mid-2013, Mrs T's consultant cardiologist referred her for a heart operation. The operation was successful and she was prescribed a number of drugs, including a blood-thinning tablet, to stop her having a stroke.

Mrs T saw the consultant cardiologist two more times. On the first occasion, he noted that her blood pressure was normal so he stopped all of her medication against her wishes. Mrs T went back to him four weeks later, complaining of being 'giddy', having blurred vision (she requested a scan of her head, which he refused) and several non-specific symptoms. Again, the consultant did not prescribe any medication.

Mrs T then went home after this consultation and fell over. She believed that she had a stroke at this time. Although she had been told that she did indeed have a stroke, there was conflicting medical opinion on this. Mrs T stated that she now has to take medication for the rest of her life and lives in fear of having another stroke.

What we found

We did not uphold this complaint. The consultant cardiologist behaved reasonably by stopping the medication at the first consultation after the operation, and also on the second occasion when he did not reinstate the medication.

Organisation(s) we investigated

Buckinghamshire Healthcare NHS Trust

Location

Buckinghamshire

Region

South East

Summary 878/February 2015

Trust managed patient's complaint adequately but gave misleading information in its response

Mrs W complained that the Trust failed to address the issues she raised in line with NHS complaints procedures.

What happened

While she was an inpatient at the Trust, Mrs W complained about her care after an operation. A ward sister attempted to provide local resolution while Mrs W was still in hospital. This was done and the complaint was closed.

After she was discharged, Mrs W complained to the Trust that her complaint had not been handled in accordance with NHS procedures, and that parts of her complaint had been left unresolved.

What we found

We did not uphold this complaint. The Trust behaved appropriately when it handled Mrs W's complaint. It carried out a thorough investigation and resolved matters to her satisfaction.

Unfortunately the Trust, in its final response letter to the complaint gave Mrs W incorrect and misleading information, which made her think that the complaint had not been handled appropriately. This meant that the complaint was investigated again.

The Trust carried out a thorough reinvestigation and once it realised the mistake in the communication it had sent Mrs W, it immediately apologised.

Organisation(s) we investigated

Hull and East Yorkshire Hospitals NHS Trust

Location

Hull

Region

Yorkshire and the Humber

Summary 879/February 2015

Poor care of a young adult with Asperger's syndrome and a depressive disorder

Mrs L complained that the Trust failed to diagnose her son, Mr H's, condition (bipolar depression) and did not correctly adjust his medication. Mrs L believed the Trust's actions caused her son's suicide attempts and a decline in his mental health, and affected his relationship with the family. She was also unhappy about the delays in the Trust's complaints procedure.

What happened

Mr H came under the care of the Trust in spring 2011 for his mental health. Staff prescribed a number of medications.

In winter 2012, a private psychiatrist reached a different diagnosis of Mr H's condition and changed his medication. The private psychiatrist wrote to Mr H's GP suggesting that he might have been on a dangerous combination of drugs.

What we found

We partly upheld this complaint. The Trust did not take all of Mr H's previously documented symptoms into consideration when it reached its original diagnosis. This caused distress, and led to Mrs L seeking a second opinion.

Trust staff made changes to Mr H's medications without recording or explaining the reasons for this. Although this caused distress, we did not consider that this caused any long-term problems or caused Mr H to become suicidal.

The Trust handled Mrs L's complaint poorly. Mrs L did not have any reassurance that it had learnt lessons from her concerns.

Putting it right

The Trust wrote to Mrs L to acknowledge the failings we identified and the impact those failings had on her and her son. It apologised for the failings, and paid her £750 compensation.

The Trust produced an action plan to address the faults we identified.

Organisation(s) we investigated

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 880/March 2015

Trust wrongly asked for clinical evidence to support claim for NHS continuing healthcare funding

Mr R complained that the Trust had not fully considered Mrs R's (his late mother's) eligibility for NHS continuing healthcare funding. Mr R also complained that the Trust asked his representative to provide evidence and records to support his request for funding.

What happened

Mr R, via his representative, asked for a retrospective assessment of Mrs R's eligibility for NHS continuing healthcare funding for the period from summer 2004 to spring 2007.

The Trust said that it would only review the periods from early winter 2005 to late autumn 2006, and autumn 2006 to spring 2007. This was because checklist screenings to decide how much NHS continuing healthcare funding Mrs R was eligible for had been carried out for the remainder of the claim period. The Trust asked Mr R's representative to provide evidence and records to support the request for funding. The Trust would not progress the continuing healthcare funding review without these.

What we found

We partly upheld this complaint. The Trust correctly declined to consider part of the review period because the appropriate checklist screenings had already been done. However, the Trust had a duty to review Mrs R's eligibility for NHS continuing healthcare funding as there was evidence that she may have needed such care. In these circumstances, it was the Trust's responsibility to gather the evidence and records needed to complete the review.

Putting it right

The Trust acknowledged its failings and apologised to Mr R for the injustice caused. The Trust continued the review of Mrs R's eligibility for NHS continuing healthcare funding for the periods winter 2005 to autumn 2006, and autumn 2006 to spring 2007. The Trust reviewed its processes for dealing with requests for retrospective reviews and brought these in line with guidance.

Organisation(s) we investigated

Oxford Health NHS Foundation Trust

Location

Oxfordshire

Region

South East

Summary 881/March 2015

GP failed to carry out adequate assessments of a patient's symptoms or take into account mental health issues when treating them

Mr K was unhappy that his GP did not carry out sufficient examinations or investigations or give him access to appropriate treatment. He felt that his GP did not take into account his frail mental health when treating him.

What happened

Mr K saw his GP several times over many months to discuss his painful foot and his blocked nose. He felt that the GP was always rushed and did not carry out sufficient examinations or investigations or help Mr K access appropriate treatment. He also felt that the GP did not take into account his mental health problems when treating him. This caused Mr K pain, and contributed to pre-existing mental health issues, which caused anxiety and depression and impacted upon his family and religious life. Mr K also complained about the delays that occurred when the GP dealt with his initial complaint about these matters.

Mr K left the Practice because he was dissatisfied with the service he received. His new GP dealt with the symptoms to Mr K's satisfaction; Mr K had surgery on his nose to relieve those symptoms and medication and podiatry treatment for his foot condition.

What we found

We partly upheld this complaint. The GP kept very brief records of his examinations of Mr K, which sometimes made it difficult to interpret what he was treating Mr K for. The GP did not examine Mr K's foot and nose conditions correctly and did not have in place systems for reappraisal of Mr K's conditions. The GP's examinations and record keeping were not in accordance with established General Medical Council guidelines. The GP treated Mr K appropriately for his mental health conditions by referring him for psychiatric services, but he did not consider the distress that his failure to investigate the foot and nose symptoms caused Mr K.

As a result of these failings, there was a delay of five months before Mr K had appropriate treatment from his new GP for the foot condition and a delay of six months before he had appropriate treatment for his nose condition.

The GP was not at fault with regards to the complaint handling issues and gave appropriate treatment and referrals for Mr K's mental health symptoms.

Putting it right

The GP acknowledged and apologised for the failings. He paid Mr K compensation of £1,000 to recognise the distress and inconvenience caused by these failures. He agreed to reflect on his actions and to discuss these with his responsible officer. He also agreed to write to Mr K to confirm that the discussion had taken place and to outline the lessons he had taken from this case and how he intended to put that learning into practice.

Organisation(s) we investigated

A GP practice

Location

Greater London

Region

London

Summary 882/March 2015

Trust appropriately discharged older patient from hospital but failed to make sure that he was assessed before he went home

Mrs N complained that the Trust prematurely discharged her husband, Mr N, in early 2013. He was readmitted to hospital the following day and died nine days later.

What happened

Mr N went into hospital complaining of shortness of breath. He was coughing up large quantities of thin fluids and was confused. Staff treated him for a chronic obstructive airways disease. After he had been treated in hospital for seven days, he was keen to go home and his consultant decided that he was fit to be discharged and requested that a joint physiotherapy and occupational therapist assessment be carried out to establish if he was able to manage at home when he was discharged.

Mr N was discharged from hospital the same evening, but without having this joint assessment carried out. He was readmitted to hospital eight hours later because he was vomiting blood. He died nine days after this.

Mrs N complained that her husband was discharged prematurely because he still had a chesty cough and was very confused. She felt this resulted in his readmission when his condition worsened. Mrs N was seeking an acknowledgement of failings and an apology from the Trust.

What we found

We partly upheld this complaint. Mr N was not prematurely discharged from hospital by the consultant. However, there was a failing because the physiotherapist and the occupational therapist did not assess Mr N before he was discharged. However, we did not consider that this failure contributed to the fact that Mr N was readmitted to hospital some hours later complaining of haematemesis (the vomiting of blood).

Organisation(s) we investigated

West Hertfordshire Hospitals NHS Trust

Location

Hertfordshire

Region

East

Summary 883/March 2015

Failure to follow up a patient's symptoms delayed cancer diagnosis

Staff at the Trust examined Mrs G when she went to hospital with chest pain and difficulty breathing. They sent her home with antibiotics. The Trust failed to tell her GP about test results, and this delayed her diagnosis of lung cancer.

What happened

Mrs G went to the hospital in summer 2011, complaining of chest pains and difficulty breathing. She had a chest X-ray and a scan to exclude the chance of a blood clot in her lungs. Staff diagnosed her with pleurisy and sent her home with antibiotics.

Over the next few weeks, Mrs G became progressively more unwell. She visited her GPs several times, but it was not until autumn that the GPs became concerned and arranged further tests. In winter 2011, Mrs G went into hospital as an emergency with severe pain and difficulty breathing. Following investigations, she was diagnosed with incurable lung cancer, and had palliative care.

In summer 2012 Mrs G became severely unwell again, but although she had an emergency appointment at the Trust, staff took no action until she was admitted a week later with pneumonia. Mrs G's condition initially seemed to improve with antibiotics, but she deteriorated and died several days later.

What we found

We partly upheld this case. The hospital should have made arrangements to follow up Mrs G's care in its chest clinic. Instead, the consultant wrote to Mrs G's GP, wrongly stating that her chest X-ray was clear and with no mention of any need for follow up. This led to a delay in Mrs G being diagnosed with lung cancer. If she had been followed up correctly, she would have been seen at the chest clinic in late summer 2011, and it was likely she would have been diagnosed with lung cancer then. While this would not have changed her prognosis or the course of the disease, Mrs G had to suffer for over two months longer before she received appropriate pain relief and palliative care.

There were no failings on the part of the GP Practice, because it received the wrong information when the Trust discharged Mrs G from hospital.

A delay in starting antibiotics in summer 2012 did not contribute to Mrs G's death.

Putting it right

The Trust apologised for the failings identified, and created an action plan to make sure that all patients who require follow up in future have this arranged for them.

Organisation(s) we investigated

A GP practice

Tameside Hospital NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 884/March 2015

Excessive dose of vitamin D was unlikely to have caused subsequent symptoms

Mr G complained that a doctor at the Trust prescribed him an excessive dose of vitamin D. He said that he consequently suffered symptoms from the toxicity of this medication, which led to deterioration in his mental health. He had to give up his job and this consequently had severe financial implications for him.

What happened

Mr G saw a specialist registrar in rheumatology in summer 2012. Blood tests showed that his vitamin D levels were very low at 14.1 nmol/L - the normal range is between 50 and 150 nmol/L. Trust staff prescribed Mr G a 28-day course of vitamin D3 (cholecalciferol) at a dose of 50,000 IU (international units) daily.

Mr G took the vitamin D as prescribed for approximately two weeks, but stopped taking it after he began experiencing severe stomach pain.

When Mr G stopped taking the vitamin D, he became 'hyper' and had a lot of energy. He also said that his sleeping pattern changed, he had a racing mind and was unable to sleep. He became agitated and anxious and began experiencing periods of fear and panic attacks. He said that he became unable to concentrate or sit still at work and he eventually had to give up his job. He was diagnosed with anxiety and depression.

On the advice of the specialist registrar, Mr G then began taking vitamin D again. He said that during this time his symptoms of anxiety, depression, agitation and fear became more severe. A blood test carried out in winter 2012 showed that his vitamin D level was 236.3 nmol/L.

Mr G said that by this point he had slipped into a deep depression. During 2013 he began to have chest pains and an irregular heartbeat and went into hospital for this. He also said that he was admitted to hospital because of his deteriorating mental health, and was prescribed a number of medications to try to manage this.

In spring 2013 Mr G complained to the Trust about the dose of vitamin D prescribed to him. In its response, the Trust said that Mr G's health problems were not caused by the vitamin D the specialist registrar had prescribed.

Mr G was dissatisfied with this and came to us in summer 2014.

What we found

We partly upheld this complaint. In summer 2012, trust staff prescribed Mr G a significantly higher dose of vitamin D over a shorter period of time than would normally be recommended for the treatment of vitamin D deficiency. Even though Mr G stopped taking the vitamin D after approximately two weeks, and so did not complete the full dose prescribed, the amount of vitamin D he took during this period was higher than would normally be expected.

However, it was unlikely that the dosage of vitamin D in Mr G's case caused any form of toxicity that would have contributed to or caused his subsequent physical and mental health symptoms.

While Mr G claimed that a later course of vitamin D prescribed to him was done so on the advice of the specialist registrar, there was no evidence that the specialist registrar had recommended or prescribed any further prescription of vitamin D that Mr G may have taken.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 885/March 2015

Poor care exacerbated family's distress after mother's death

Delays in Mrs B's cancer diagnosis, failings in communication, and poor nursing care left her family wondering if her death could have been prevented.

What happened

Mrs B was referred to hospital in spring 2012 to investigate a range of symptoms she had had for about two months. She was initially diagnosed with atypical polymyalgia rheumatica; a condition that causes pain, stiffness and inflammation in the muscles around the shoulders, neck and hips. Trust staff ordered more tests and a CT scan, and these suggested diverticular disease.

Mrs B's symptoms continued and her health deteriorated. Two months later, she went into hospital. Staff diagnosed Mrs B with a stroke caused by a blocked artery in her neck, and a tumour in her bowel. Although doctors arranged for bowel surgery, they postponed this until they could identify if surgery to unblock Mrs B's artery was needed. By the time clinicians carried out bowel surgery in the middle of the year, the cancer had spread extensively and was incurable by surgery. Mrs B died in autumn 2012.

Mrs L, Mrs B's daughter, complained to the Trust that staff had misdiagnosed her mother in the early stages of her illness, and she had therefore had steroid medication that was inappropriate. She complained that Trust staff had not diagnosed cancer earlier. Mrs L also raised a number of other concerns about Mrs B's care, about poor communication and about the attitude of the staff involved.

What we found

We partly upheld this complaint. Polymyalgia rheumatica was a reasonable initial diagnosis on the basis of Mrs B's initial symptoms. Therefore we could not conclude she had been misdiagnosed. However, clinicians should not have excluded cancer as a possible diagnosis after the first CT scan. This was compounded when staff did not arrange urgent follow up after the scan.

There were delays in diagnosing Mrs B's cancer, but, given the information available to us, we were unable to say whether or not her death could have been prevented if the diagnosis had been made earlier. There were failings in how staff communicated with Mrs B and her family, and this made their distress worse. Poorly completed records also left the family without reassurance that the nursing care given to Mrs B was appropriate, and this added to their anxiety.

Putting it right

The Trust wrote to Mrs L to acknowledge the failings and to apologise for the distress caused.

It also paid her £1,000 to recognise the distress caused by the loss of opportunity to diagnose Mrs B's cancer earlier and to know if an earlier diagnosis could have led to curative rather than palliative bowel surgery.

The Trust developed an action plan which addressed the failings we found and to identify the reasons for them, and described the learning and actions it would take as a result.

Organisation(s) we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 886/March 2015

Poor communication by Trust

Ms T complained that her mental health team left her confused when it poorly communicated to her about what support was in place for her after she was discharged. She was also unsure how the Trust would deliver mental health care, during a time of extensive changes to these services.

What happened

Ms T received support from the community mental health team. In 2013, she complained about the adequacy of support available to her.

Also in 2013 Ms T's psychiatrist told her that it was possible to discharge her from the service because she was considered to be stable and functioning well. The decision to discharge her was made the following year and she was discharged in spring 2014. In summer 2014, the Trust made major changes to how it delivered mental health care.

Ms T was concerned that the decision to discharge her was made because of her complaint. She also believed it was inappropriate to discharge her. She said this had left her without access to appropriate support mechanisms, and she was confused and frustrated.

What we found

We partly upheld this complaint. We found there were no failings in the discharge arrangements; however, we noted that there was no written care plan when Ms T was discharged, and there was poor communication about what would happen to her when the structure of mental health care provision at the Trust changed. We also found there was poor complaint handling because there were conflicting messages in the complaint response about whether or not she had a key worker.

Putting it right

The Trust apologised to Ms T for the failings, clarified what was currently available to her, and reviewed its approach to complaint handling to make sure that there were no conflicting messages in future.

Organisation(s) we investigated

Coventry and Warwickshire Partnership NHS Trust

Location

Warwickshire

Region

West Midlands

Summary 887/March 2015

Delays in diagnosis compromised patient's chances of a better outcome from surgery

Mrs P's hernia was not correctly diagnosed for over three weeks. Surgery was eventually carried out, but Mrs P did not recover from this and died in autumn 2013.

What happened

Mrs P went into hospital a few days after a fall. She felt dizzy, had a bruised leg and abdominal pain, and was vomiting. Trust staff initially diagnosed swollen lymph nodes in her groin.

Mrs P continued to complain of abdominal pain. Some 11 days after she went into hospital, tests suggested she might have a bowel obstruction, and there were also signs that she was starting to experience systemic infection. Mrs P also developed an abscess at the site of her abdominal swelling.

Although staff in the Trust's acute medical unit and its critical care unit monitored Mrs P, she continued to deteriorate. A surgical review of Mrs P's CT scans, carried out more than three weeks after her admission, led to a diagnosis of a hernia that had partly obstructed her bowel. Mrs P had surgery to remove the affected part of her bowel; but she did not recover and died three weeks later.

The Trust's serious incident investigation identified that staff had misinterpreted the first CT scan images. Inadequate reviews, examinations, and handovers between medical staff had compounded this, particularly when Mrs P was moved between wards. This meant that staff did not recognise the significance of Mrs P's symptoms.

The Trust was unable to say if Mrs P would have survived if it had made the correct diagnosis earlier. However, it acknowledged that she would have been in a stronger position for surgery.

What we found

The Trust misinterpreted the original scan images, and failed to review the images again when Mrs P's condition did not improve. Staff also missed opportunities to consider a diagnosis of obstructed bowel because of a hernia. We were unable to conclude that Mrs P would have survived surgery if the Trust had made the correct diagnosis earlier; however, we agreed with the Trust that the delay compromised her chances of a better outcome. This caused distress to Mrs P's family because they will never know whether or not the outcome could have been different.

The Trust had already taken appropriate action to discuss the misinterpretation of the original images in its radiology discrepancy meeting. But its serious incident investigation report was not as robust as it could have been.

Putting it right

The Trust wrote to Mrs P's son and daughter to acknowledge the failings we found and to apologise for the distress caused. It also paid £500 compensation to them both. It developed an action plan to identify the reasons for the failings and the learning the Trust had taken from these, and to explain what it would do differently in the future.

Organisation(s) we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

South East

Summary 888/March 2015

Trust failed to treat a suspected stroke

Mrs F complained that staff missed opportunities to identify a stroke when she went to a minor injuries unit in early 2014.

What happened

In early 2014, Mrs F was taken ill while away from home. She was unable to stand or to use her right arm properly and a taxi driver took her to the minor injuries unit. The taxi driver, who had known Mrs F for a number of years, told the reception staff that he thought that she had had a stroke. Nursing staff saw Mrs F. They recorded she was feeling unwell, left a message for her GP to contact her at home and then discharged her. Mrs F was alone at home until her GP contacted her about two hours later. By this time, her condition had worsened and her GP identified that she was suffering from a stroke and called an ambulance. Mrs F was admitted to hospital where staff confirmed that she had had a stroke.

What we found

Minor unit injuries staff did not properly check Mrs F for the possibility of a stroke. Front line staff, even those in a minor injuries unit, should recognise the possibility of a stroke and complete an appropriate diagnostic assessment. That did not happen in Mrs F's case. Staff also did not refer her to another practitioner, which would have been appropriate. The Trust said that reception staff cannot pass on suspected diagnoses from members of the public to nurses, however, it is reasonable to expect reception staff to alert clinical staff when a potentially serious case presents.

The taxi driver knew Mrs F and could have given useful information about any change in her normal function or behaviour. Time is critical when treating stroke, but as a result of the failings, Mrs F had to wait longer for her condition to be identified. That caused her additional worry and meant her symptoms worsened. The Trust also put Mrs F at risk of further health problems because of the delay in diagnosis.

Putting it right

The Trust apologised for the failings we identified and explained what it had done to make sure it had learnt the lessons from the failings so that they are not repeated.

Organisation(s) we investigated

East Coast Community Healthcare CIC

Location

Norfolk

Region

East

Summary 889/March 2015

Trust's poor communication and Council's failure to make appropriate sick leave arrangements led to anxiety and distress

Mrs A complained that her father, Mr B, suffered heart failure because he was not given enough of his medication. She said that her father's discharge from hospital after his readmission was delayed because of faults by the Council.

What happened

Mr B went into hospital in autumn 2013 after he fell at home. His family were unhappy about the care at the hospital so Mr B was transferred to a private suite and they paid for his care. During this time, his condition deteriorated. Mr B did not take his regular medication for fluid retention, and it was started again five days later at a lower dose than usual. The next day, Mr B was transferred to an NHS rehabilitation ward. He started antibiotics five days later for a urinary tract infection, however, he deteriorated further.

He developed fluid on the lungs as a result of his heart condition, and was treated for a chest infection. Mr B's condition stabilised and he was discharged home the next month. There was some confusion in how paperwork was sent from the Trust to a social worker, especially when the social worker was absent on sick leave.

The morning after Mr B arrived home, his family called an ambulance and Mr B was taken to another hospital where he suffered a heart attack. He was discharged home again the next month.

What we found

We partly upheld this complaint. We investigated this complaint jointly with the Local Government Ombudsman because it concerned the actions of a local authority as well as an NHS organisation.

There was fault in the initial care given to Mr B. However, the Trust took action and we were satisfied this had addressed this issue. We did not find fault in Mr B's discharge from the rehabilitation ward or the information given in the discharge letter. We found no evidence of fault in the care and treatment on the rehabilitation ward, although the Trust was at fault because it could not give us copies of Mr B's physiotherapy records or his full occupational therapy records. However, this fault did not lead to an injustice. We found fault in the Trust's communication with Mr B's family, which led to anxiety and distress, and also in the way the complaint was handled.

The Council failed to make sure alternative arrangements and contacts were made available when the social worker working on Mr B's case was absent from work.

Putting it right

The Trust wrote to Mrs A to acknowledge the fault identified, and to apologise for the anxiety and distress this caused. It also drew up plans to address the faults found and reassure Mrs A that it would make improvements to make sure that it takes learning from what happened.

The Council agreed to apologise to Mrs A for the delay in responding to her original complaint in early 2014 and for the failure to update the social worker's voicemail. They also agreed to make sure there were systems in place to effectively manage social workers' caseloads when they were absent, including the need to divert calls or change messages when front line staff were absent from work.

Organisation(s) we investigated

Frimley Health NHS Foundation Trust

Royal Borough of Windsor and Maidenhead Council (investigated by the Local Government Ombudsman)

Location

Surrey

Region

South East

Summary 890/March 2015

Hospital failed to identify or act on woman's dementia needs while in hospital; social services failed to assess her mental capacity

Ms J complained that her grandmother who was in her nineties had poor care after she went into hospital with breathing difficulties. She also complained social services failed to give her grandmother the support she needed.

What happened

Mrs G, who was in her nineties, had lung disease and dementia. She lived with her son, and her other children gave her care and support. Mrs G had a package of care from the Council to help with her personal care.

Mrs G went into hospital with breathing difficulties. Clinicians found she had heart failure, problems relating to her lung disease, and had had a mild heart attack. The Trust discharged Mrs G into the care of her family, with a package of care arranged by the Council, after she had been in hospital for over a week.

Before Mrs G's discharge, her family talked to the hospital and social services about whether they felt able to look after her at home. Social services said Mrs G needed a therapy assessment and possibly a placement in intermediate care (short-term care provided free of charge for people who need help to recover after being in hospital). But the next day Mrs G's daughter told hospital and social work staff the family felt able to look after Mrs G at home.

Mrs G had to be readmitted to hospital a few weeks later because of a bloody swelling on her hand, where she had pulled a tube out in hospital.

Mrs G continued to receive a package of care from the Council, and went into respite care for three days a few months after she was discharged from hospital.

What we found

We investigated this complaint jointly with the Local Government Ombudsman because it concerned the actions of a local authority as well as an NHS provider.

The Trust failed to identify and take into account Mrs G's additional needs as a person with dementia, after she was admitted to hospital. This meant many aspects of her hospital care were not appropriately changed to meet the needs of a dementia patient. This resulted in distress to Mrs G and her family.

The Council failed to formally assess Mrs G's capacity to make decisions about her care. But it is unlikely that decisions about Mrs G's care arrangements would have been different if this had happened. The Council did not share a copy of its care review document until Mrs G's family asked for it. But the Council properly assessed Mrs G's needs and provided a suitable care package to meet those needs.

Putting it right

The Trust wrote to Ms J to apologise for the faults we identified. It also produced an action plan confirming the action taken to address the faults in clinical care we found.

We asked the Council to apologise and to make sure that if there were concerns about a person's capacity, an assessment is made and recorded as part of the discharge planning process. We also asked the council to make sure that scheduled reviews and care plans for those with dementia were promptly shared with a suitable representative.

Organisation(s) we investigated

Stockport NHS Foundation Trust

Stockport Metropolitan Borough Council (investigated by the Local Government Ombudsman)

Location

Greater Manchester

Region

North West

Summary 891/March 2015

Cardiac care appropriate but Trust staff did not document an adverse reaction to an enema

Ms L complained that her mother's significant heart problems were overlooked when the Trust planned to carry out ovarian cyst surgery. She was also concerned that her mother had an enema even though an earlier one had caused an adverse reaction.

What happened

Ms L's mother Mrs D, who was in her eighties, had a history of heart problems. After she was diagnosed with a cyst on her ovary, a cardiologist and an anaesthetist reviewed her suitability for surgery. They put safeguards in place so that surgery could go ahead. But the operation was cancelled on two occasions. When Mrs D was admitted for a third time, her heart medication was stopped and, despite previously reacting badly to an enema, she was given another one in preparation for surgery. This led to Mrs D suffering a heart attack, and she became too unwell for the planned surgery to go ahead. Instead, Mrs D was admitted as an emergency to the intensive treatment unit and the cyst was drained. Mrs D made a gradual recovery and went back to a ward but unfortunately her condition deteriorated a few days later and she died. Ms L believed plans should not have been made to operate on her mother and the cyst should have been drained earlier instead.

What we found

We partly upheld this complaint. In most respects, the Trust managed Mrs D's care appropriately and it had properly explained what had happened and how it had learnt lessons from the complaint. However, we found that Mrs D's adverse reaction to the first enema had not been documented and this meant staff did not consider withholding a second enema. We could not say with any certainty that the second enema led to Mrs D suffering a heart attack. However, we recognised that Ms L was left with the uncertainty because of this, and this was an injustice to her.

Putting it right

The Trust apologised for the upset and uncertainty Ms L had suffered and reviewed its policies on preoperative enemas to make sure that it complied with the appropriate guidelines. We did not recommend a financial payment because Ms L told us she did not want us to.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 892/March 2015

Failings in care and treatment did not increase loss of vision

Mr Y complained that when he went to the A&E department at the Trust's hospital with a shadow in his right eye, staff sent him away without a proper examination or treatment. A review at another trust found problems in the blood supply to the optic nerve.

What happened

In summer 2012, Mr Y went to the A&E department at the Trust because he had a shadow in his right eye that had begun a couple of days earlier. An emergency nurse practitioner carried out an initial assessment that included taking a history of the symptoms he was experiencing, and testing his vision.

The emergency nurse practitioner contacted a member of the ophthalmology team for advice. The clinical records showed that the emergency nurse practitioner had a discussion with the on-call ophthalmology registrar, who said that Mr Y should be seen by an optician first. The Trust's appointment system shows that staff then made an appointment for Mr Y to be seen in the eye clinic that evening. However, there was nothing documented in the records to explain who had made this appointment or the rationale for it. Furthermore, staff did not tell Mr Y that they had made this appointment for him. Mr Y told us that after his discharge, it was too late to go to an optician and so he went home.

Mr Y's condition worsened overnight and so the next day he went to an eye hospital. Staff found he had high blood pressure and admitted him. He had treatment to control his blood pressure. While in hospital, Mr Y told staff that his vision was deteriorating. After an ophthalmologic review, clinicians felt that Mr Y's visual loss was likely due to anterior ischaemic optic neuropathy (AION), a condition where the small arteries to the optic nerve suddenly become blocked.

Mr Y complained to the Trust about the care and treatment he received in A&E and the ophthalmologist's failure to examine him. He believed that if he had had an appropriate ophthalmologic review, his high blood pressure would have been noticed. This would have allowed clinicians to take action to treat it sooner and his loss of vision could have been reduced.

Mr Y asked the Trust for the name and registration number of the ophthalmologist who gave the advice to the emergency nurse practitioner, so that the General Medical Council (GMC) could consider whether any further investigation was appropriate. The Trust investigated and responded to Mr Y's complaint, but it was unable to identify the doctor concerned. Mr Y was still unhappy with the responses he got and he decided to complain to us.

What we found

We partly upheld this complaint. There were failings in the care Trust staff gave Mr Y when he went to A&E in summer 2012. Staff did not take his blood pressure or put a management plan in place, or tell him about an appointment they had made for him. This meant he did not have an appropriate review.

However, earlier treatment of Mr Y's blood pressure would not have led to a better outcome. His visual loss would not have been reduced if an ophthalmologist had reviewed him when he went to the Trust's hospital. Mr Y's visual loss was caused by AION. Unfortunately, there is no proven treatment for AION itself and no treatment has been shown to improve the visual loss that AION causes.

There were also failings in the Trust's record keeping. The emergency nurse practitioner did not document the name of the ophthalmologist she spoke to in the clinical records department, so there was no record of who gave advice on this case. Mr Y could therefore not know the identity of this person and the GMC did not have the opportunity to consider whether to investigate a complaint about this doctor's fitness to practise.

That said, we considered that our investigation had given Mr Y an independent review of his concerns so he had not been unduly disadvantaged by the Trust's inability to identify the ophthalmologist concerned.

Putting it right

The Trust wrote to Mr Y acknowledging and apologising for the impact of its failings. It also agreed to prepare an action plan to describe what it had done or planned to do, to make sure that it had learnt from its failings in record keeping and its failure to ensure that Mr Y received appropriate medical review.

Organisation(s) we investigated

Western Sussex Hospitals NHS Foundation Trust

Location

West Sussex

Region

South East

Summary 893/March 2015

Failings in out-of-hours GP care for Alzheimer's patient after he attacked his wife

Mr B, who had Alzheimer's disease, lived with his wife of many years. In a display of very uncharacteristic behaviour, he physically attacked and verbally abused her, and she was forced to leave home for her own safety.

What happened

After this incident, Mr B's son, Mr P, tried to get help from NHS 111 and social services but he had difficulty getting a doctor to assess his father. The incident happened over a bank holiday weekend and there was only one social worker on duty to provide out-of-hours mental health assessments in the county. She decided that Mr B did not need to be assessed urgently, given that Mrs B had left the house, and because of other, more urgent, cases.

Early the next evening, a triage GP, who Mr P had contacted through the 111 NHS service had left a message for the out-of-hours mental health services asking them to call back, but they did not. Mr P eventually managed to get an out-of-hours GP to visit his father later that evening. The out-of-hours GP carried out an assessment of Mr B's mental state by asking him ten simple factual questions but found no evidence of confusion.

The out-of-hours GP spoke to Mr P on the phone and then waited for him to arrive at Mr B's house. There were conflicting accounts about whether the out-of-hours GP made efforts to contact the mental health services' out-of-hours number. The out-of-hours GP did not feel that he could do more for the family and advised them that this was a domestic issue and they should seek advice about Alzheimer's from Mr B's own GP when the surgery reopened (which would have been two days later).

Mr P was extremely unhappy and felt that his mother's wellbeing had been jeopardised by the failure of the out-of-hours GP to take action. He arranged for another out-of-hours GP to visit the following day, and she diagnosed a possible urine infection and prescribed antibiotics. When Mr B's GP surgery reopened, Mr B's son and daughter persuaded him to attend, and staff carried out a mental health assessment. Mr B was admitted to hospital under a section of the *Mental Health Act* and remained there for a number of weeks.

What we found

We partly upheld this complaint. The first out-of-hours GP had not documented appropriate attempts to rule out a physical cause for Mr B's confusion, in particular a urine infection. He said in a statement that he had made multiple calls to the out-of-hours mental health services but he had not documented these either. We did not feel that the care he gave was in line with established good practice, or that it was reasonable for the first out-of-hours GP to treat this incident as a domestic dispute, given Mr B's Alzheimer's and his very uncharacteristic behaviour.

That said, we did not think that the outcome would have been very different even if the first out-of-hours GP had acted in line with established good practice. The staffing situation over the bank holiday weekend meant that there was only one social worker covering the whole county. This was a distressing situation for the family and a complex one in terms of the overlapping responsibilities and communication difficulties between different agencies.

However, we did not feel that the distress was solely caused by the failings we identified.

Putting it right

The Clinical Commissioning Group apologised to the family and took action to make sure that record keeping by the out-of-hours agency's GPs was in line with General Medical Council guidance, following an audit that was already underway.

Organisation(s) we investigated

East and North Hertfordshire Clinical Commissioning Group (CCG)

Hertford Urgent Care Centre

Location

Hertfordshire

Region

East

Summary 894/March 2015

Trust gave overdose of insulin twice

Mrs J went into hospital with shortness of breath and a cough. She had heart failure. Nurses gave Mrs J more insulin than she needed and did not report this as an incident. They then gave her too much insulin again.

What happened

Mrs J had type 2 diabetes and was cared for by her daughter. When she went into hospital with heart failure, nurses gave Mrs J twice an overdose of insulin. They failed to notice initially that Mrs J had hypoglycaemia (very low blood sugar), which had been caused by the overdose of insulin, and they did not treat this for a period of time. Nurses did not ask doctors to review Mrs J, and the amount of insulin Mrs J was prescribed was not changed on the electronic prescription system, so she was overdosed again.

Mrs J was increasingly unwell from the heart failure and had the distressing symptoms of hypoglycaemia. Her condition deteriorated and she died a few days after she had been admitted to hospital.

Mrs J's daughter, Mrs K, complained about the care given to her mother and that the lack of management of her mother's diabetes had caused her to deteriorate further. She did not believe the Trust had done enough to address the failings identified or to report them.

What we found

We partly upheld this complaint. There were a number of missed opportunities to review Mrs J's insulin and take action, both in terms of communicating with Mrs J and her family and also in staff reporting incidents. The Trust recognised some failings but we did not consider the action taken had gone far enough. The Trust did not recognise that there were a number of incidents that staff should have reported. There was also no action taken to address this lack of reporting.

The Trust recognised the failings in the diabetic management of Mrs J. However, we considered that the Trust needed to show how it would make sure that staff managed patients with diabetes in line with the relevant Trust policy.

Mrs J suffered unnecessarily with the symptoms of hypoglycaemia which caused her and her family significant distress during the last few days of her life.

Putting it right

The Trust apologised to Mrs K and her family and paid £500 in recognition of the unnecessary distress caused to them. The Trust agreed to prepare an action plan to address the issues identified in the reporting of incidents and diabetic management.

Organisation(s) we investigated

Heart of England NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 895/March 2015

Freelance income reimbursed after Trust error

The Trust reimbursed Mr G over £4,000 for loss of freelance income after a seven-month delay in informing him of scan result.

What happened

Mr G's left kidney was removed in early 2012 after clinicians found a cancer on it. Mr G had regular reviews and CT scans. In spring 2013, Mr G had a scan just before he had a morning appointment with an oncologist. That afternoon, a radiologist reported that there was a small mass on Mr G's remaining kidney that looked like cancer. However, the oncologist only picked this up when Mr G had another scan in autumn 2013, some seven months later. Mr G had a successful operation on his kidney later in 2013 but as a result, he was unable to fulfil lucrative freelance contracts. Mr G complained to us about the Trust's delay in informing him about the second tumour. He asked for compensation for the distress and loss of self-employed income, and he wanted the failures to be acknowledged.

What we found

The Trust failed to take action after Mr G's CT scan result in spring 2013. The oncologist wrote to Mr G's GP confirming that the scan showed no evidence of cancer, but wrote the letter before he had received the radiologist's report which confirmed the tumour. Although Mr G had freelance earnings during spring 2013, his losses would have been minimal if he had undergone the operation at that time. We agreed with the Trust that the delay made no difference to Mr G's prognosis or the operability, but this was good luck rather than design.

Putting it right

The Trust reimbursed Mr G £4,750 for the lost income caused by its delay in acting on the spring 2013 scan. It also apologised for the impact of the failings and explained what should have happened when scans were reported on the same day as review appointments, and how it would prevent the mistakes from happening again.

Organisation(s) we investigated

Imperial College Healthcare NHS Trust

Location

London

Region

Greater London

Summary 896/March 2015

Practice's anticoagulation service failed to identify patient with complex conditions

Mr S complained that his GP Practice did not manage his warfarin medication appropriately. He felt he should have been referred to hospital earlier.

What happened

After Mr S's heart valve replacement surgery, the anticoagulation team at the Practice took over his warfarin (medicine to reduce blood clots) management. He had unstable test results and subsequently had a stroke.

What we found

The Practice should have identified that Mr S's medical history, together with his poor test results, showed his high stroke risk factor. The Practice should have referred him back to hospital to monitor his anticoagulation treatment. However, there was no evidence that an earlier referral would have prevented the stroke.

Putting it right

The Practice apologised for failing to refer Mr S earlier and made changes to improve its anticoagulation service.

Organisation(s) we investigated

A GP Practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 897/March 2015

Doctor failed to make adequate record of examination

Mrs D complained that two doctors failed to diagnose a fracture in a bone surrounding her hip replacement.

What happened

Mrs D saw the first doctor at her GP surgery and complained of pain to her back, groin and hip. She was unable to walk unaided and told the GP that she thought the pain was coming from her hip replacement. The GP examined Mrs D, recorded her medical history and diagnosed sciatica. She prescribed painkillers for Mrs D.

The second GP visited Mrs D at home three days later because her pain had worsened and she was bedridden. This doctor examined her and referred her for an X-ray. She decided that Mrs D would be able to travel by car to where the X-ray would be taken, and she prescribed painkillers. The second GP then left.

Mrs D's husband called an ambulance as Mrs D was unable to walk. She was taken to A&E. She was later diagnosed with a fracture in a bone surrounding her hip replacement.

What we found

We partly upheld this complaint. The entry in Mrs D's clinical records of her first appointment was not a precise enough record of what was examined or what was found. However, there was insufficient evidence in either the GP or ambulance records to suggest that Mrs D had a fracture then, or at her later appointment. We could not conclude that Mrs D suffered an injustice as a result.

The second doctor should have called an ambulance to take Mrs D to hospital.

Putting it right

The Practice had already acknowledged that it had learnt that when patients feel there is a problem that is not being adequately addressed, they are usually right.

The Practice had also apologised for failing to telephone for an ambulance to take Mrs D to hospital.

Organisation(s) we investigated

A GP Practice

Location

Hampshire

Region

South East

Summary 898/March 2015

Although a child's mental health care and treatment were overall of a good standard, some care was unhelpful

Mr H complained about the care and treatment the Trust gave L, his daughter. Mr H complained that L's treatment was inappropriate and because of this, she suffered trauma and became withdrawn. Mr H also complained about the way the Trust handled his complaint.

What happened

L was admitted to an assessment and treatment unit for children with severe emotional and behavioural disorders in early summer 2013. She had Asperger's syndrome (an autistic spectrum disorder) and severe obsessive compulsive disorder (OCD).

Later in summer 2013 Mr H decided to remove L from the unit because he felt that the daily care and treatment she had was not always consistent and helpful for her. L was eventually discharged from the unit's care the following month.

Mr H subsequently complained to the Trust about the care and treatment L had received. He said that she had experienced bullying, intimidation and ill treatment by staff during her time there and that staff did not have any skills or knowledge of Asperger's syndrome. He alleged that staff told L that she had an 'attitude problem' as she would not look them in the eye. Mr H also said that staff walked in on L while she was using the toilet and that she was not allowed to use the phone to call home as agreed. He also raised concerns that L did not receive any treatment during her time at the unit.

The Trust investigated Mr H's complaint and responded. However, Mr H was dissatisfied with the response, and complained to us.

What we found

Overall, the care given to L was of a good standard, with comprehensive assessments and care plans designed to treat and rehabilitate her. We were satisfied that generally staff had a good understanding of her needs and her difficulties.

There was, however, a failing by the Trust because of a lack of consistency about L using the telephone to call home. Obsessional rituals, desire for sameness and resistance to change are inherent to L's diagnosis of Asperger's Syndrome and OCD and therefore it was unhelpful that there were multiple plans in place. This would have caused confusion and frustration for Mr H and L.

L was assaulted by another child on the ward and there was a failing in how this was managed. As a young person with problems in social communication and peer relationships, L was likely to have been especially distressed by such assaults. While the Trust had acknowledged that it could have dealt with the matter better, and had apologised for the upset caused, it could have done more to recognise the impact of this on both Mr H and L. It could have explained what action it had taken to make sure that it had learnt from this aspect of Mr H's complaint.

Finally, there were failings in how the Trust handled the complaint, namely delays and lack of acknowledgement of correspondence. This would have been a source of frustration for Mr H and would have led to him feeling that his complaint was not being treated seriously. The Trust had not formally recognised the shortfalls in its complaint handling or offered Mr H a formal apology for this. It had also not explained what it had done to prevent the same thing happening again.

Putting it right

The Trust wrote to Mr H acknowledging the failings we had identified and the impact these had had on him, and apologising for this. It also prepared an action plan that described what it had done or planned to do, to make sure that it had learnt from these failings.

Organisation(s) we investigated

South London and Maudsley NHS Foundation Trust

Location

Greater London

Region

London

Summary 899/March 2015

GP acted appropriately when patient was diagnosed with rare lung condition

Mrs C felt that the GP Practice did not manage her husband's chest complaints and severe joint pain properly. She felt that clinicians should have reached a diagnosis of pulmonary fibrosis sooner and treated it.

What happened

Mr C was a patient at the Practice. From winter 2010 to summer 2013 he went to the Practice with a number of problems including chest infections, breathing difficulties and pain in his joints. He was examined and treated for all these symptoms. In spring 2013, after a chest X-ray, Mr C was diagnosed with pulmonary fibrosis, a rare condition that causes scarring of the lungs.

In summer 2013 Mr C went to the Practice with breathing difficulties. Staff gave him oxygen and called an emergency ambulance. He went to hospital and staff put him on a ventilator in the critical care unit, where he was treated for pneumonia and pulmonary fibrosis.

Mr C's health continued to deteriorate and he died later that month.

What we found

We did not uphold this complaint. The GP at the Practice examined and treated Mr C by carrying out chest X-rays and lung function tests. These investigations proved normal and Mr C chest infection symptoms improved following treatment.

It was clear that the GP responded appropriately to Mr C's symptoms, in line with established good practice. The GP's investigations were correct and until the X-ray in spring 2013, none of them would have suggested pulmonary fibrosis.

Organisation(s) we investigated

A GP practice

Location

Lancashire

Region

North West

Summary 900/March 2015

Missed opportunity to diagnose infantile spasms

In 2009 Mr and Mrs A took B, their six-month-old child, to the Practice because he was having possible seizures.

What happened

Mr and Mrs A said that it was difficult to describe their son's symptoms (rolling of the eyes and seizing up) and they brought a video to show the doctor. A GP registrar, a doctor training to be a GP, suggested that the symptoms were due to infantile colic but advised them to return if there was any recurrence. The symptoms continued for a couple of months.

In 2014 Mr and Mrs A complained to the Practice. They said that B had developmental issues and that paediatricians said that B had in fact suffered infantile spasms. Mr and Mrs A complained that the GP registrar should have done more and that there was a missed opportunity to get help sooner for B.

They also complained that the Practice did not supervise GP registrars appropriately.

The Practice provided a response and also arranged a local meeting, but Mr and Mrs A were unhappy with the outcome and so complained to us.

What we found

We partly upheld this complaint. The Practice had provided appropriate supervision for the GP registrar. However, there was a failing in the GP registrar's actions.

The failing was not that the GP registrar missed the diagnosis of infantile spasms (which is an uncommon condition) but that she failed to recognise that this was not infantile colic.

The GP registrar should have sought help from a more experienced GP, who could have made the diagnosis and given an appropriate referral to a specialist.

If diagnosed appropriately, B would have undergone an urgent examination and received treatment. There was a good chance that medication would have completely suppressed the infantile spasms at the time.

B's parents were distressed by his illness and they continue to be distressed by his developmental delay. However, we could not say that if the failing had not happened, B's developmental problems, and therefore their distress, would have been avoided.

Although it was unlikely that the outcome for B would have been any different if the GP registrar had acted differently, we concluded that there was a missed opportunity to get immediate treatment for B to relieve his symptoms. In addition, both B and his family will have to live with not knowing whether more could have been done to prevent or minimise his difficulties.

Putting it right

The Practice provided a further apology for the failing and paid Mr and Mrs A £1,000 compensation to recognise the impact of this on them. It also explained how it would make sure that patients know that they may be seen by a GP registrar.

Organisation(s) we investigated

A GP practice

Location

Leicester

Region

East Midlands

Summary 901/March 2015

Missed opportunity to identify decay in a child's tooth meant it had to be extracted

Mr and Mrs T complained that poor dental care and treatment between spring 2009 and summer 2013 meant that their daughter, Miss T, had to have an adult tooth taken out because of decay. Mr and Mrs T said that Miss T endured three months of pain until the tooth was extracted.

What happened

Miss T had a filling put into her lower right tooth in late summer 2011. Miss T had further appointments at her dental Practice in spring 2012, winter 2012 and summer 2013.

At the appointment in summer 2013, dental Practice staff diagnosed Miss T with a fractured lower right tooth. It was documented that she had decay in the pulp of the tooth (this is the central part of the tooth where the nerves, blood vessels and connective tissue are) and irreversible pulpitis (a condition in which the pulp of the tooth becomes inflamed, causing pain and pressure in the tooth). Practice staff told her that the tooth needed root canal treatment or extraction under local anaesthetic. Miss T was referred to have the tooth extracted, which happened in early autumn 2013.

Mr and Mrs T complained that the dental Practice had given their daughter poor care and treatment that resulted in the extraction of her tooth. The dental Practice's parent company (the provider) subsequently handled the complaint.

Mr and Mrs T received a response to their complaint in summer 2014. The response concluded that the dentist's examination in November 2012 did not reveal any decay in the lower right tooth. It also found that had the dentist found or suspected any decay or a cavity, they would have investigated the tooth. The conclusion was that the dentist provided appropriate treatment to Miss T in winter 2012 and with Miss T's best interests at heart following current clinical guidelines.

Mr and Mrs T were dissatisfied with the response and complained to us in summer 2014.

What we found

On the balance of probabilities, given the extent of the decay in Miss T's tooth by the time of the appointment in summer 2013, it is likely that the decay was present at the time of her previous dental appointment in winter 2012. We considered it likely that the decay was not adequately removed from Miss T's tooth before the filling was put over the top of it in late summer 2011. As a result, the decay was able to progress beneath the filling until summer 2013, when the tooth fractured.

The X-ray examination of Miss T's teeth was not carried out in line with established good practice. If such an X-ray examination had been done, particularly at the appointment in winter 2012, the decay in Miss T's tooth could probably have been identified sooner and the extraction avoided. As a result, there was a missed opportunity to identify the decay in the tooth and avoid extracting it.

Putting it right

The provider wrote to Mr and Mrs T acknowledging the failings we had identified and apologising for the effect this had on Miss T. It also paid Mr and Mrs T £1,500 to recognise the avoidable loss of Miss T's tooth; the significant pain she experienced because of the extensive decay before the tooth was extracted, and to contribute towards the cost of dental treatment to address the missing tooth.

The provider agreed to prepare an action plan describing what it had done or planned to do to make sure that lessons were learnt from this matter and to prevent the same thing happening again.

Organisation(s) we investigated

A dental practice

Location

Hertfordshire

Region

East

Summary 902/March 2015

CCG did not explain its decision not to fund surgery

Mrs G submitted an individual request for funding for surgery that would not normally be funded by her local clinical commissioning group (CCG).

What happened

The CCG decided not to authorise funding for surgery for Mrs G. It said that Mrs G's body mass index raised concerns about her safety if surgery went ahead.

Mrs G argued that there were significant clinical reasons for the surgery that overrode the potential dangers which the CCG had not taken into account. She said that the reasons made her case 'exceptional'. Exceptionality is a requirement if funding is to be awarded.

Mrs G appealed against the CCG's decision. The CCG re-examined the facts of the case but reached the same decision.

What we found

We partly upheld this complaint. When we look at individual funding request cases we will not, as a rule, overturn the decision on eligibility made by the NHS.

In this case, the individual funding request panel based its judgment on clinical advice. The panel had access to the clinical facts and made its decision accordingly.

However, we were concerned about the explanation the CCG gave Mrs G, through her GP, to support its decision. This did not mention why the CCG considered that Mrs G was not exceptional, meaning that Mrs G did not have a full explanation of the decision not to award funding.

Putting it right

The CCG left it open to Mrs G to submit a further application for funding. Therefore, we did not believe that Mrs G had suffered any injustice because of the shortcomings in the explanation she received.

Organisation(s) we investigated

Sunderland Clinical Commissioning Group (CCG)

Location

Tyne and Wear

Region

North East

Summary 903/March 2015

No delay in Practice's bowel cancer diagnosis but it gave misleading information after review

Mrs K complained that the Practice failed to diagnose her mother Mrs J's bowel cancer early enough to avoid emergency surgery. The Practice carried out a significant event review after Mrs K complained, but it then failed to address areas identified as needing improvement.

What happened

Mrs J was a patient at the Practice. In late winter 2013, her GP ordered a blood test after she reported some weight loss and abdominal pains. The test results showed anomalies and Practice staff made an appointment to see Mrs J the following month. However, very soon after, an out-of-hours GP diagnosed a bowel obstruction and Mrs J was admitted to hospital as an emergency. Clinicians found a large tumour on Mrs J's bowel during surgery, and a scan identified another cancer on her liver. Mrs J died a year later.

Mrs K complained that the Practice failed to diagnose bowel cancer in time to prevent the emergency surgery.

What we found

We partly upheld this complaint. The Practice could not have diagnosed Mrs J's condition any earlier, and gave appropriate care and treatment.

Unfortunately when the Practice sent Mrs K its final response to her complaint, it included misleading information from its significant event review. Mrs K felt this showed it had not handled the complaint properly.

Putting it right

The Practice acknowledged the failings we identified and took steps to address the issues raised in the review.

Organisation(s) we investigated

A GP practice

Location

Warwickshire

Region

West Midlands

Summary 904/March 2015

Poor care during birth prevented new mother enjoying first months with her baby

Mrs F complained that when she was a patient on the Trust's maternity ward, staff gave her an injection into her buttock through the birth pool water. She said that this led to her developing an abscess.

What happened

Mrs F gave birth to her son in a birth pool in summer 2013. Clinical staff gave her an injection to speed up the delivery of the placenta and reduce the risk of heavy bleeding. Mrs F and her husband, who was present at the time, both recalled that the injection was given through the water in the birth pool before she was helped out of the pool.

Several weeks later Mrs F developed an abscess in her left buttock in the area she was injected. This caused her significant pain, and impaired her quality of life and her ability to carry out normal activities with her newborn child. Mrs F's GP initially gave her antibiotics but had to undergo a procedure to treat the abscess. The subsequent wound took many weeks to heal.

What we found

Trust staff should have given Mrs F the injection under sterile conditions in order to prevent infection. Administering an injection through the unsterile water in a birth pool, as Mrs F and her husband recalled happened, would have contaminated the sterile needle before it pierced the skin. There was lack of detailed information in the medical records about how Mrs F was given the injection or what position she was in at the time but the records confirmed that she was still in the pool when she had the injection.

Taking this into account, it was more likely than not that Mrs F had the injection in the contaminated water and developed an abscess as a result.

This was not in line with established good practice and was therefore a failing.

Mrs F suffered unnecessary pain for around six months as a result of the abscess. It took some time for the abscess to be identified and after the procedure to treat it, the wound took a long time to heal. Mrs F had to make around 30 visits to a clinic for repacking and redressing of the wound, and these were painful and inconvenient, and expensive. During this time, Mrs F experienced a considerable amount of pain and discomfort, which prevented her from sleeping. She was also unable to enjoy normal activities with her baby son, such as walking with him in a pram, lifting him or swimming.

Mrs F had intended to return to work in early 2014 after her maternity leave. However, as her wound was still healing from the incision and drain procedure, she was unable to return to work until later in the year. So she also lost two months of earnings.

Putting it right

We were reassured that the Trust had already acknowledged the failings in Mrs F's care and had apologised for the distress this had caused. The Trust had also taken appropriate action to prevent other patients having a similar experience by making procedural changes and updating its policy.

However, the Trust should have also offered Mrs F a financial remedy. This would have recognised the pain and discomfort she suffered, her lost opportunity to enjoy normal activities with her baby son, the inconvenience and expenses she incurred attending treatment for her abscess and two months of lost earnings.

The Trust paid £2,000 compensation and £2,178 for lost earnings.

Organisation(s) we investigated

Tameside Hospital NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 905/March 2014

Hospital did not give woman prescribed medication

Mrs C was in her eighties and had several medical conditions. When she went into hospital, staff did not prescribe her usual medications and did not rectify this for 36 hours. Mrs C died soon after.

What happened

Mrs C had several health conditions including heart problems, breathing problems and high blood pressure. She went into hospital having had diarrhoea for four days and was dehydrated. Mrs C's carer gave hospital staff a list of her medications but staff did not prescribe them, so Mrs C did not have them. Mrs C's daughter (Mrs F) realised the problem the following day and told staff. Clinicians prescribed the medications and staff gave them to Mrs C from the following morning, over 36 hours after she had been admitted. Later that afternoon, Mrs C began to have chest pains and staff gave her morphine. She died the next morning.

Mrs F complained that the failure to give her mother her medications had caused her to suffer unnecessary pain and ultimately caused her deterioration and death. Mrs F said this caused her emotional distress. Mrs F also complained about some comments made by staff.

What we found

We partly upheld this complaint. The Trust missed several opportunities to check that Mrs C was being prescribed the right medications. Although we did not find that this made Mrs C suffer or her health deteriorate, it caused Mrs F distress because she would always have doubts about whether her mother's life could have been saved and whether she suffered unnecessarily

There was no evidence that staff deliberately offended Mrs F. We found no reason to criticise any of the statements staff made that Mrs F complained about.

Putting it right

The Trust apologised to Mrs F for the doubts she had been left with because of its failure to prescribe Mrs C's medications. It also explained to Mrs F how it planned to improve the standard of care in this area.

Organisation(s) we investigated

Chesterfield Royal Hospital NHS Foundation Trust

Location

Derbyshire

Region

East Midlands

Summary 906/March 2015

GP practice adequately assessed patient's condition but did not make sure she could get to a hospital

Mrs P complained that the Practice failed to recognise the severity of her condition and did not assess her properly during a consultation. Mrs P felt her life was put at risk as a result because she was not transferred to hospital as an emergency patient.

What happened

Mrs P had had several operations because of a medical condition. After her last operation, she went to the dressings clinic at the Practice for wound assessment. Mrs P was bleeding heavily so the Practice nurse asked a GP to assess her.

After the assessment, the GP suggested that Mrs P went back to hospital to have the wound looked at. Mrs P left the Practice and made her own way to a hospital.

When she arrived at hospital, Mrs P had surgery the same day to treat a liquefied haematoma (a blood-filled swelling). She believed the surgery was life saving and so felt the Practice had failed in its duty of care to her by failing to arrange transport for her to hospital when she was bleeding so heavily.

What we found

The GP at the Practice failed to adequately assess Mrs P's condition and failed to arrange her safe transfer to hospital. Although this final element did not endanger Mrs P, it meant she suffered unnecessary distress.

Putting it right

The Practice and the GP accepted our findings and apologised to Mrs P. The Practice paid her £250 compensation and drew up an action plan to prevent a recurrence.

Organisation(s) we investigated

A GP practice

Location

West Sussex

Region

South East

Summary 907/March 2015

Patient was not told there may be complications in hip replacement surgery

When Mr P developed problems after his hip replacement, he was unprepared because the surgeon had not fully explained the risks of the surgery beforehand.

What happened

Mr P had hip replacement surgery in winter 2013. His recovery progressed well until early spring 2014, when he suddenly experienced extreme pain at the top of his right leg. He was referred for a scan, and this showed that he had a gap in the muscle attached to his femur bone. This was a known complication of hip replacement surgery. The surgeon did not recommend further surgery to try to resolve the situation because it was unlikely to be successful.

What we found

We partly upheld this complaint. Although there were no failings in the care and treatment Mr P received during and after his surgery, he had not been told beforehand that this particular known complication could arise.

Putting it right

The Trust apologised for what had happened and put a plan in place to learn lessons to make sure they do not happen again.

Organisation(s) we investigated

Spire Washington Hospital

Location

Tyne and Wear

Region

North East

Summary 908/March 2015

Failure to put in place a clear plan for a man coming to the end of his life caused avoidable distress

Ms F complained that a clear care plan was not put in place for her father, Mr F, although his death was expected. She complained that, as a result, there was confusion and her father's illness was treated inappropriately.

What happened

Mr F had kidney disease and, in late 2011, it was found his condition had deteriorated and was irreversible. Mr F decided not to proceed with dialysis and chose to follow a conservative management course.

In early 2012 Mr F was living at home. He saw district nurses regularly. When he became unwell, Ms F telephoned his GP and, after a discussion about what might be needed, Mr F went to A&E by ambulance. He was admitted to hospital and, two days later, was discharged to a care home for a short-term respite stay.

Mr F became acutely unwell and had to go back to hospital less than a week later. He went onto a general medical ward over the weekend and was then discharged to a hospice, where he died.

Ms F complained because she said her father was left distressed and exhausted at an already difficult time, and his last days were neither peaceful nor dignified.

Ms F said it was very distressing to witness this sequence of events and she had been left with a feeling of guilt as she tried to reassure her father that she would sort everything out.

What we found

We partly upheld this complaint. We investigated this complaint jointly with the Local Government Ombudsman because it concerned the actions of a local authority as well as NHS organisations.

There was fault in the actions of Mr F's GP Practice and in the actions of the Care Trust responsible for the district nursing service. They missed an opportunity to put in place an agreed care plan for Mr F when it was known he was coming to the end of his life. Had these faults not occurred, the final weeks of Mr F's life could have been more thoughtfully and appropriately managed. As such, he suffered avoidable distress, as was Ms F, who witnessed these events.

There was also fault on the part of the GP for the care home (the Medical Centre) because a lack of communication about a possible GP visit caused additional avoidable stress and anxiety.

In addition, there was evidence of avoidable delays in how the Care Trust handled Ms F's complaint. An Area Team handled the complaint in the later stages, and also caused delay. This created further stress and anxiety.

We did not find fault in the actions of the local authority or the Acute Trust Mr F was admitted to.

Putting it right

The Medical Centre, the Practice, the Care Trust and the Area Team all wrote to Ms F to apologise for their failings and for the injustice caused.

Under embargo until 00.01 Thursday, 22 October 2015

Organisation(s) we investigated

A GP practice

A medical centre

Greater Manchester Area Team (the Area Team)

Pennine Acute Hospitals NHS Trust (the Acute Trust)

Pennine Care NHS Foundation Trust (the Care Trust)

Oldham Metropolitan Borough Council (investigated by the Local Government Ombudsman)

Location

Greater Manchester

Region

North West

Summary 909/March 2015

Failure to provide a fully funded care package

Mr H complained that not all elements of his son, R's, care plan were being funded by the NHS. He also complained that R was denied access to housing he had previously been nominated for, after he was found eligible for NHS continuing healthcare funding.

What happened

Before late winter 2013, R's care package was provided by the local authority. R was living in a bungalow. He had previously been nominated for a local authority flat, which professionals involved in his care felt met his needs.

In late winter 2013, R was found eligible for NHS continuing healthcare funding. At the transition meeting, Mr H was told that the offer of the local authority flat had been withdrawn.

An NHS continuing healthcare care plan was put together with contributions from Mr H, R's psychiatrist and his clinical psychologist. Within the care plan, it was stated that one of the outcomes was for 'R to have increased opportunities for meaningful therapeutic and social activities everyday'. A list of specific activities was included. Mr H was told that these activities would not be funded by the NHS.

What we found

We partly upheld this complaint. The withdrawal of the offer of the local authority flat was outside the Clinical Commissioning Group's (CCG's) control so we did not uphold this part of the complaint.

The care plan was too specific. It should have broadly set out what R's care needs were and what interventions were needed to meet these. The care plan, which had been agreed by the multidisciplinary team, indicated that R had therapeutic needs that needed to be met by the care package. In accordance with the National Framework, the CCG was responsible for meeting these needs. We said that this did not necessarily mean that the CCG had to fund the specific activities in the care plan. However, if the CCG did not consider that these particular activities were appropriate to meet R's needs, it should still have made sure that suitable alternatives were provided.

Putting it right

The CCG wrote to Mr H apologising for the failings we identified and for the injustice these failings caused. It also agreed to arrange to fund appropriate interventions to make sure R's therapeutic needs were met in line with his care plan.

Organisation(s) we investigated

Dorset Clinical Commissioning Group (CCG)

Location

Dorset

Region

South West

Summary 910/March 2015

Hospital fully acknowledged failures in care

Ms L, who was in her seventies, was dissatisfied with how her diabetes was managed during a hospital admission and the fact that the discharge summary was incorrect. She also complained about the attitude of one of the nurses.

What happened

Ms L went into hospital for breast reconstruction surgery because of earlier breast disease. She was unhappy that her diabetes was not managed in her usual way and the discharge summary wrongly stated that she had cancer. Ms L also complained that one of the nurses was rude and made accusations about Ms L and her family.

Ms L was dissatisfied with the Trust's response to her complaint and therefore asked us to investigate her concerns.

What we found

We did not uphold this complaint. The Trust failed to thoroughly explore Ms L's needs relating to her diabetes and this led to failings in the management of her condition. The discharge letter was inaccurate and this caused distress. The Trust had already given an appropriate remedy for these issues by apologising and putting measures in place to stop them happening again.

Because there were no independent witnesses, we were unable to take a view on the attitude of the nurse. But we noted that the Trust had provided appropriate apologies and had discussed the issues with the staff involved.

We considered that the Trust had already done all that we would expect to resolve Ms L's complaint.

Organisation(s) we investigated

Nottingham University Hospitals NHS Trust

Location

Nottingham

Region

East Midlands

Summary 911/March 2015

Poor communication with patient during premature birth

Failings by doctors to communicate with Mrs E during premature labour contributed to her uncertainty and distress during the birth of her baby son, who subsequently died.

What happened

In summer 2013, Mrs E was pregnant and she had a cervical suture because she had a history of miscarriage. The procedure can help an expectant mother avoid a miscarriage. Trust staff had no concerns at Mrs E's follow-up appointment at 17 weeks, and the plan was to review her at 28 weeks. However, in autumn 2013, when Mrs E was just over 22 weeks pregnant, she went into the Trust's maternity assessment unit with abdominal pain and back ache. Staff examined her and found she was in labour. Staff transferred her to the labour ward, where they removed the cervical suture. The consultant obstetrician decided to examine Mrs E but did not tell why. During the examination, Mrs E's membranes ruptured and a baby boy was quickly delivered and he died shortly after birth. Mrs E complained that the Trust made no attempt to save him.

What we found

We partly upheld this complaint. There were no failings regarding the clinical care given to Mrs E and the decision not to carry out resuscitation was in line with standard practice. However, there were failings in the doctors' communication with Mrs E because they did not make sure that she understood what was happening or what was going to happen. This led to uncertainty and stress for Mrs E during a very traumatic experience.

Putting it right

The Trust wrote to Mrs E to apologise and paid her £500 in recognition of the impact that its lack of communication had had on her.

Organisation(s) we investigated

Bradford Teaching Hospitals NHS Foundation Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 912/March 2015

Care funding case closed before agreed deadline

A primary care trust (PCT) made an unreasonable decision to close a request for a review of historic continuing care funding.

What happened

In summer 2012 Mrs B, via her solicitors, asked the PCT to review her mother's eligibility for continuing care funding from spring 2010 onwards. When her mother, Mrs C, went into a care home. Mrs B asked for a retrospective review, and a current review.

The PCT assessed that Mrs C did not meet the criteria for a continuing care assessment from winter 2012 onwards. Mrs B's solicitors disagreed with the decision but did not provide any detail to support their view.

In early 2013 the PCT asked the solicitors for more information to support the claim for the earlier period. It asked them to send the documents by the middle of the next month. The solicitors asked for more time, and the PCT agreed an extension until spring. Close to the date, the PCT wrote to tell the solicitors the case had been closed. This letter crossed with a letter from the solicitors asking for leniency as Mrs C had recently died and they were awaiting instructions from the executors of her will. The PCT did not respond to the solicitors' letter.

The solicitors provided the necessary information in winter 2013 and the clinical commissioning group (CCG, which had by then taken over from the PCT) declined to reconsider the case. The solicitors complained about the PCT's decision to close the case, but the CCG deemed it had been appropriate. Mrs B then came to us.

What we found

We partly upheld this complaint. The CCG acted reasonably on the request for a current review because the PCT had made a decision and the solicitors had not given it any information to support their dissatisfaction with the decision.

As for the retrospective review, it was inappropriate for the PCT to close the claim before the agreed deadline. The PCT should have acknowledged the solicitors' letter informing it of Mrs C's death and considered whether to allow any more time.

Putting it right

The CCG agreed to reconsider the decision to close Mrs B's case.

Organisation(s) we investigated

Wokingham Clinical Commissioning Group (CCG)

Location

Wokingham

Region

South East

Summary 913/March 2015

Delay in diagnosis of breast cancer

Trust did not carry out a needle biopsy when symptoms indicated possible disease, and it took a long time for doctors to diagnose breast cancer.

What happened

Ms N found a lump in her breast and her nipple started to invert. Her GP referred her to the Trust, where staff carried out a mammogram in early summer 2013 and was indeterminate on the left breast, but was reported as normal on the right. An ultrasound scan the same day did not confirm any sign of disease. The Trust carried out an MRI scan the next month because the previous investigations had not led to a diagnosis. The MRI scan was inconclusive and staff carried out biopsies the following month. Doctors diagnosed her with breast cancer and she had a mastectomy. This was almost eight weeks after Ms N was first seen.

What we found

We partly upheld this complaint. The Trust should have carried out biopsies at an earlier stage and, in line with relevant guidelines, performed a triple assessment (clinical assessment, mammography and/or ultrasound imaging, and core biopsy and/or fine needle aspiration) in a single visit. The Trust did not have the facilities to do this.

There was evidence that the Trust missed opportunities to arrange a needle biopsy (a procedure where some cells are taken from a lump using a fine needle under local anaesthetic) at the first assessment in summer 2013 (at the same time as the ultrasound scan) and again after the MRI scan. These delays meant that the diagnosis of the disease was similarly delayed.

There were also failings in the way Trust staff communicated with Ms N about her care before her diagnosis. After diagnosis, there were no problems in communication or support.

There was no evidence that the delay in diagnosis led to Ms N undergoing more aggressive treatment but it caused anxiety and stress because of the lack of diagnosis.

Putting it right

The Trust acknowledged the service failings we identified and apologised to Ms N for them. It paid her £500 in recognition of the worry and distress caused by the delay in diagnosing her cancer. It also drew up an action plan to make sure that lessons were learnt from these failings.

Organisation(s) we investigated

Surrey and Sussex Healthcare NHS Trust

Location

West Sussex

Region

South East

Summary 914/March 2015

Patient put at risk of blood-borne diseases by Practice nurse

A Practice nurse injected Ms K with a used needle while giving her the influenza vaccine. As a result, Ms K had to have tests and treatment for potential blood-borne diseases.

What happened

In winter 2013, Ms K went to her GP practice for an influenza vaccine. The Practice nurse injected her with a previously used syringe when she gave the vaccine. Ms K was exposed to the risk of blood-borne diseases, and consequently had to undergo tests and have an accelerated course of hepatitis B vaccinations. Ms K received the all clear in summer 2014. The incident caused Ms K significant distress and anxiety because she was worried she might have contracted HIV or hepatitis.

Ms K complained to the Practice, which gave written responses and also met her. However, the matter remained unresolved.

What we found

We partly upheld this complaint. There was a failing on the part of the Practice because the Practice nurse had injected Ms K with a previously used needle. This should not have happened and the Practice nurse should have realised the syringe had already been depressed before she tried to give the vaccine. The Practice accepted that this incident should not have happened but its written response did not specifically acknowledge that the Practice nurse was responsible.

The response only said that it had not been possible to identify who had put the used syringe back in the fridge. We considered that the Practice needed to acknowledge and address the Practice nurse's responsibility.

We also considered the Practice's actions after the incident. The Practice took the matter seriously and it reported the matter to the appropriate organisations such as Public Health England. It also improved the security of the vaccine fridges to ensure only clinical staff had access to them, and all staff had extra training to make sure they complied with the relevant protocols and procedures. These actions were appropriate in trying to avoid a similar incident happening again. The Practice also gave Ms K reassurance and carried out appropriate screening for any blood diseases. Overall, we considered the Practice's actions to address the serious error by the Practice nurse were appropriate and reasonable. However, while we welcomed the Practice's actions, we considered it should do more to put things right by offering Ms K compensation for the stress and anxiety she had suffered while she waited to find out whether she had any blood-borne diseases.

Putting it right

The Practice wrote to Ms K to acknowledge and apologise for the Practice nurse's actions and the impact this had on her. It also paid her £500 as compensation for the injustice that she suffered.

Organisation(s) we investigated

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 915/March 2015

A GP Practice failed to discuss the implications of stopping medication for a dying patient

Mrs W asked the Trust and the Practice to investigate the actions of the GP in stopping her husband Mr W's tinzaparin (medication to prevent blood clots) injections when he was dying, and the actions of the district nurse following her husband's death.

What happened

Mrs W's husband was receiving palliative care for pancreatic cancer from the Trust and the Practice. Mrs W complained that the GP at the Practice failed to discuss the implications of stopping Mr W's tinzaparin injections. A few days before Mr W's death, a nurse caring for him asked the GP if the tinzaparin injections should be stopped. He told the nurse to ask Mrs W, without explaining what would happen to Mr W if he no longer received this medication. Mrs W also complained that in the moments after her husband's death, a district nurse entered the house and removed the batteries from the syringe driver so as to prevent it from bleeping, which was inconsiderate to Mrs W's grieving.

What we found

We partly upheld this complaint. The Practice failed to follow General Medical Council (GMC) guidance on end of life care because the GP should have assessed Mr W's condition, taking into account his medical history and Mr and Mrs W's knowledge and experience of his illness. The GP should have used his specialist knowledge, experience and clinical judgment, together with Mr and Mrs W's views, to identify which investigations or treatments were clinically appropriate and likely to benefit Mr W. The GP did not do this and this was a failing that caused undue distress and confusion at an exceptionally difficult time.

In the minutes following Mr W's death, a district nurse and a health care assistant visited. This caused Mrs W great distress because they appeared insensitive and uncaring about her husband's death.

When the Trust received Mrs W's complaint, its locality manager visited Mrs W to discuss the issues raised. Following an investigation, the Trust sent a written response the next month in which it passed on apologies from the district nurse and the health care assistant involved. They explained that they had reflected on the comments and feelings and recognised that the situation was very sensitive. They explained that it was not their intention to be uncaring and insensitive. The Trust acknowledged that the district nurse should not have removed the batteries from the syringe driver very soon after Mr W's death.

In its investigation, the Trust confirmed that the district nurse and the health care assistant had reviewed their communication approach, with other members of the team, for future visits. The Trust also spoke to the district nurse to confirm the Trust's syringe pump policy. The Trust's actions were reasonable and demonstrated it had learnt lessons from the complaint.

Putting it right

We were not satisfied that the Practice had done enough to stop a situation like this happening again. At our request the Practice apologised to Mrs W for the impact these failings had on her. It also agreed to improve its palliative care procedures to take into account the GMC guidance.

Organisation(s) we investigated

East Lancashire Hospitals NHS Trust

A GP practice

Location

Lancashire

Region

North West

Summary 916/March 2015

Trust acted to improve communication shortfalls

Mr S complained about the care and treatment his wife received before she died, as well as the way staff communicated with him and his family.

What happened

Mrs S was admitted in a critical state and developed sepsis as a result of pneumonia. She was started on the Liverpool Care Pathway (an end-of-life care pathway that was intended to provide the best quality of care possible for dying patients) for some of her admission, but this was withdrawn as a result of family concerns.

What we found

We did not uphold this case. Mrs S's general care and treatment, including that of the nursing and palliative staff, was in line with established good practice and we saw no failings in the use of the end-of-life pathway. We saw much discussion with family members and no sign that their views had been ignored. The Trust had already acknowledged and remedied some lapses in its standard of communication and had taken action to learn from the complaint.

Organisation(s) we investigated

Wirral University Teaching Hospital NHS Foundation Trust

Location

Merseyside

Region

North West

Summary 917/March 2015

No fault in decision to transfer patient's treatment to a different hospital

Mr A complained that a member of the Trust's staff made an untrue allegation about him which resulted in his treatment being transferred to a different site. He also complained about how the Trust dealt with the matter. He said the allegation caused him unnecessary stress and inconvenience.

What happened

Mr A needed dialysis three times a week. In summer 2013 his dialysis was moved to a different renal unit because of concerns about his behaviour towards his named nurse.

The nurse said Mr A stroked her arm as she put a blood pressure cuff on him, and he telephoned her later that day to arrange to speak to her individually. Later that week, Mr A handed a note to the nurse. The note thanked the nurse for her care and asked her to speak to him in a private room after his dialysis had finished.

The nurse showed the note to the sister on the unit. The sister spoke to Mr A while he was dialysing. She explained the note was inappropriate. Mr A apologised, explained he had not intended to upset the nurse, and said it would not happen again.

After his dialysis had finished, Mr A spoke to the sister again. According to Mr A, the sister had no further concerns and he believed the matter had been resolved. According to the sister, Mr A claimed the nurse had told him she loved him; however, he then retracted this statement.

The sister said she warned Mr A if he continued to harass the nurse, she would have to move his treatment. She said Mr A said he understood but then asked if he could give the nurse a card and gift he had in his bag.

A renal consultant telephoned Mr A later that afternoon to tell him his dialysis would be transferred to a different hospital with immediate effect.

A week later the Trust hand delivered an acknowledgement of responsibilities agreement to Mr A while he was having treatment at the new site. The agreement said it had been alleged Mr A had displayed inappropriate behaviour towards a member of staff. The agreement confirmed Mr A's treatment would remain at the new site. It asked him to refrain from using inappropriate language, gestures or comments towards any member of staff and said he was not to contact staff at the original site. If Mr A did not abide by these conditions he could be excluded from its premises, and criminal or civil proceedings could be taken against him. The acknowledgment of responsibilities agreement was copied to Mr A's GP.

What we found

There was no fault on the part of the Trust with regard to the decision to transfer Mr A's dialysis. The decision was appropriate, given the concerns about Mr A's behaviour.

On the whole, the Trust's handling of the matter was reasonable. However, the Trust was at fault for issuing an acknowledgement of responsibilities agreement to Mr A. He had not displayed any further inappropriate behaviour after he was given an informal warning by the renal consultant so a further sanction was not needed. This was not in line with the Trust's policy and was unfair to Mr A.

Putting it right

The Trust acknowledged the fault with regard to the acknowledgement of responsibilities agreement and apologised to Mr A. It also removed it from his health records.

Organisation(s) we investigated

Heart of England NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 918/March 2015

A&E doctor did not thoroughly assess patient's symptoms

Ms K had a disease of the central nervous system. When she went to A&E with a headache and stomach pain, the doctor did not properly assess whether she was suffering from a flare up of her illness.

What happened

Ms K's condition affected her vision. She went to A&E at the Trust by ambulance, because she had a headache, fever and stomach pain. Ms K said that she was also suffering from visual deterioration. The ambulance records stated that Ms K told the paramedic that her vision had deteriorated and she also informed A&E staff about this. This was not recorded in the notes, and the Trust said that the doctor was not told of this.

The A&E doctor concluded that Ms K's symptoms were probably caused by constipation and migraines. She was referred for follow up with her GP. The next day Ms K's vision deteriorated further and she contacted her neurologist, who prescribed high-dose steroids. Her vision returned to what it was before the flare up.

What we found

We partly upheld this complaint. Because of the differing accounts of events, and in the absence of any other evidence, we could not say whether Ms K mentioned visual deterioration to the A&E doctor. Her other symptoms did not indicate that medical staff should have suspected that her illness had flared up. However, clinicians should have taken further actions to investigate Ms K's condition and checked her vision because of her ongoing disease. The doctor should have reviewed the ambulance records.

These omissions meant that Ms K's assessment was not as thorough as it should have been. If the assessment had been carried out appropriately, Ms K would probably have been prescribed steroids in A&E. As she got steroids the next day, we did not think that it was likely that the delay affected her condition. However, it was clearly distressing for Ms K, and she had to get in touch with her neurologist in order to get the medication that she should have been given in A&E. This caused Ms K frustration.

Putting it right

The Trust apologised to Ms K, and agreed to explain how it will make sure that ambulance records are available to A&E staff in future.

Organisation(s) we investigated

King's College Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 919/March 2015

Trust failed to carry out risk assessment designed to prevent injury to a patient

Mr B complained that his wife's leg was injured while she was an inpatient at the Trust. He believed the injury could have been avoided if proper bed rail protection had been used.

What happened

Mrs B was an inpatient at the Trust. She suffered from dementia as a result of Parkinson's disease and a haematological condition meant she injured easily. During her stay at the Trust she injured her leg.

Mrs B gave three separate accounts of the cause of her injury, which happened while she was alone. This included falling, hitting her leg and trapping her leg in the bed rails.

Mrs B's husband believed the final explanation was the cause of his wife's injury and complained that the bed rails should have been protected.

What we found

It was not possible to find the cause of Mrs B's injury. We established that the injury most probably happened when Mrs B tried to get out of her bed unaided and that she could have hurt herself on many different parts of her bed. However, it was clear that a bed rail risk assessment had not been carried out during Mrs B's stay.

Putting it right

The Trust acknowledged its failings, apologised to Mr B and paid him £250 in compensation. The Trust carried out a serious event investigation and acknowledged that Mrs B should have had padded bed rails to provide better protection from injury. The investigation also identified areas for training. The Trust's risk management committee also agreed to obtain better bed rail protection for use by patients considered to be at risk of injury and supported by a risk assessment.

Organisation(s) we investigated

Dorset County Hospital NHS Foundation Trust

Location

Dorset

Region

South West

Summary 920/March 2015

Man left waiting in A&E for hours without explanation

Ward staff told Mr D's family that a bed was available for him on the ward. The bed manager said that the bed was no longer available and Mr D remained in A&E for some hours.

What happened

Mr D had neutropenia (a very low count of neutrophils, a type of white blood cell that helps to fight off infection) and had to be nursed in a room separately when he went to hospital due to the risk of infection to him. After being admitted to A&E, staff sent Mr D for an X-ray and his family were told a room was being prepared for him. However, Mr D was not transferred and the family found he had remained in A&E and were told that a bed was not available at that time. Staff transferred Mr D to the ward later the same day having waited some hours in A&E.

Mr D's daughter, Miss D, complained to the Trust about the care given to her father. She said that when her father was transferred to the ward, the ward sister had asked where he had been because the room had been ready for hours. Miss D said the bed manager had not checked and said someone else had needed the room.

The Trust said the room had been available on the ward when Mr D was initially admitted but this changed due to an emergency. The Trust acknowledged that there were failings in communication with Mr D's family and took action to remind staff of the importance of better communication with families. They apologised for the distress caused to Mr D and his family.

What we found

We partly upheld this complaint. The Trust had taken appropriate action to acknowledge failings and to prevent this happening again where possible. However, it had not investigated the complaint as fully as it could have done. We said it should have contacted the ward sister as part of its investigation to ask for her statement about the events that occurred.

Putting it right

The Trust apologised to Miss D and explained how it had learnt from her complaint.

Organisation(s) we investigated

South Warwickshire NHS Foundation Trust

Location

Warwickshire

Region

West Midlands

Summary 921/March 2015

Baby born in ambulance, although midwife had earlier dealt with labour appropriately

Mrs M believed that a midwife did not manage her labour appropriately when she was examined in hospital and sent home. Later that day, she called an ambulance and, on the way to hospital, had her baby in the back of the ambulance.

What happened

Mrs M complained that when she went to the hospital in labour, the midwife did not examine her properly and sent her home without further advice. She raised concerns about the midwife's communication with her and said that she had to be taken back to hospital later that day by ambulance, and that her baby was born in the ambulance.

What we found

We did not uphold this complaint. The midwife acted appropriately in managing Mrs M when she attended the maternity unit. The midwife carried out a proper examination and Mrs M was not in established labour. The midwife's care and treatment of Mrs M was appropriate and in line with established guidelines.

Organisation(s) we investigated

Gateshead Health NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 922/March 2015

Failures in investigation of woman's death

Mrs Y was in her eighties and had a history of untreated breast cancer, asthma and dementia. She was admitted to hospital vomiting blood.

What happened

Mrs Y was initially treated on an acute medical unit (the unit) and was then transferred to a ward later the same day. At some time between 4am and 5am the following morning, Mrs Y left her bed. She was found dead at 5.15am.

Her daughter, Mrs A, said that the Trust's lack of care meant that her mother was able to leave her bed and so died prematurely.

What we found

The Trust had already properly explained what happened in relation to some aspects of Mrs A's complaint and had already acknowledged that key assessments – falls risk assessment and bed rails assessment – were not completed as they should have been. It had introduced changes as a result. However, it needed to do more to make sure that changes were monitored and improvements were maintained.

We were unable to say if these key assessments had been completed, Mrs Y would have been prevented from leaving her bed.

The Trust's investigation did not take statements from all staff at an early stage and this led to information being lost, which could have helped Mrs A to understand what had happened to her mother. We also found the Trust did not keep Mrs A informed of delays in its investigation and gave her wrong information on one occasion.

Putting it right

The Trust apologised to Mrs A that statements were not taken from staff as soon as possible after events occurred, and for the failings in complaint handling. It paid her £250 compensation and told her what action it had taken to make sure records are properly completed and how compliance would be monitored.

Organisation(s) we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Thurrock

Region

East

Summary 923/March 2015

Trust provided appropriate support to mental health patient

Mr D said the Trust failed to thoroughly investigate his complaints and the poor treatment he received in 2013 caused him extreme distress.

What happened

The occupational therapy department of Mr D's employer at the time referred him to the Trust in 2007 and he was subsequently diagnosed with depression and anxiety. He continued to have regular outpatient appointments under the care of a consultant psychiatrist.

In 2013 Mr D had three outpatient appointments with different psychiatrists. He felt the reports from these appointments were inaccurate and that he should have been considered a vulnerable adult and treated accordingly. In 2014 the Trust referred Mr D for cognitive behavioural therapy (CBT).

Mr D complained that he should have received CBT sooner, because he had been an outpatient at the Trust for seven years before this was arranged. He also complained that the reports from three clinical psychiatric appointments did not accurately reflect what was discussed, and provided incorrect information about his mental health.

What we found

We did not uphold this complaint. Mr D received appropriate care for his depression and anxiety. At the time CBT services were not readily available at the Trust and the service that was available had an 18-month waiting list. The consultant appropriately concluded that this would not have been beneficial for Mr D because he had a more immediate need to access services. The consultant provided appropriate alternative psychotherapy and support for Mr D.

In relation to the three appointments Mr D complained about, we acknowledged there was a disagreement between Mr D's recollections and what was recorded. The written records did not contain the level of detail Mr D thought should have been included. However, the records were in line with relevant guidance and contained all of the information that would be expected in such a record.

Although Mr D considered there were failings in the service provided by the Trust, the evidence showed he got the care and support appropriate to his needs.

Organisation(s) we investigated

5 Boroughs Partnership NHS Foundation Trust

Location

Warrington

Region

North West

Summary 924/March 2015

GP managed patient's ruptured bicep appropriately

Mr K felt that his GP should have urgently referred him for surgery to treat his ruptured bicep.

What happened

Mr K, who was in his sixties, fell in late summer 2013. He injured his left arm when he fell onto his outstretched hand. Later the same day Mr K said he felt pain in his arm and noticed a bulge within his arm. Mr K believed that lifting heavy boxes following the initial fall caused the injury.

Mr K went to his local GP practice a month later where he complained of pain in his arm. The GP examined him and gave him analgesia to ease the pain, and referred him to orthopaedics that same day.

In winter 2013, Mr K saw an orthopaedic consultant who diagnosed him with a ruptured bicep tendon.

What we found

We did not uphold this complaint. The GP acted reasonably in conducting an examination and referring Mr K to orthopaedics on a routine basis that same day. As Mr K went to his GP a month after his injury occurred, the timescale for urgent surgical treatment had already been exceeded.

Organisation(s) we investigated

A GP Practice

Location

Greater London

Region

London

Summary 925/March 2015

GP appropriately stopped patient from driving

Mr G complained that his GP stopped him from driving while waiting for a consultation with a specialist ophthalmologist. Mr G said that he had to pay for a private consultation and this left him out of pocket.

What happened

Mr G complained about the Practice's recommendation that he stop driving because his GP felt that he did not meet the vision requirements of the Driver & Vehicle Licensing Agency (DVLA).

Mr G went for a routine eye test and the optician recommended that he be referred to an ophthalmologist through his GP. Due to the remote location of where Mr G lived and because he was dependant on driving for his livelihood, the GP upgraded the referral request from routine to urgent. Unfortunately even with an urgent referral, an appointment was not available for several weeks. The GP and Mr G had a discussion regarding the arrangement of a private ophthalmology appointment, to minimise the amount of time Mr G could not drive. Consequently the GP made an appointment for Mr G to see a consultant ophthalmologist privately. The private consultant saw Mr G and advised him that he was able to drive and that his eye sight met the DVLA requirements.

Mr G complained that the GP wrongly advised him to stop driving and he also believed it was unreasonable to suggest he pay for a private consultation to establish whether or not he met the DVLA guidelines for driving.

Mr G said that as a result, he had suffered distress and had to pay out money for the services of a private ophthalmologist.

What we found

We did not uphold this complaint. DVLA's guidance is clear that a person with a visual field defect should not drive until it is confirmed that they meet the national requirements for field of vision. The GP gave appropriate advice about Mr G continuing to drive.

The GP made the correct decision and the appropriate referral to a specialist who could give a final decision about whether or not Mr G should continue to drive.

Organisation(s) we investigated

A GP practice

Location

Cumbria

Region

North West

Summary 926/March 2015

Trust failed to act properly after finding blood in patient's stools

Mrs T and her husband, were unhappy with the standard of care her mother, Mrs M, received because the Trust did not act on what was found until after the weekend.

What happened

Mrs M was booked to have an endoscopic retrograde cholangiopancreatography (ERCP is a procedure that uses an endoscope and X-rays to look at the bile duct and the pancreatic duct).

Mr and Mrs T said that there was evidence of blood in Mrs M's stools over the weekend after the ERCP procedure and felt that the Trust should have taken action to address this. The Trust monitored Mrs M over the weekend and had four sets of observations completed on both Saturday and Sunday. The trust also made note in Mrs M's medical records of consistent black stools.

However, no action was taken to address the blood in her stools until Monday. A day after blood in Mrs M's stools was noticed, there was a severe drop in her blood pressure. Sadly she deteriorated over the following week and died.

What we found

We partly upheld this complaint. There is no specific guidance for the level of observations needed after an ERCP procedure; however, regular monitoring is required. The Trust completed regular observations of Mrs M over the weekend so we were satisfied that suitable monitoring took place that was in line with established good practice.

Although the trust appropriately recorded evidence of Mrs M passing several black stools, staff should have made a more thorough assessment of the possibility of internal gastrointestinal bleeding based on this.

As the black stools were clearly recorded in the notes, the lack of further assessment or escalation suggested failings in the actions of the Trust. The Trust should have thoroughly reviewed Mrs M when the bleeding was recorded. However, taking into account Mrs M's condition, it is unlikely that the drop in her blood pressure was preventable, even if the Trust had acted when the black stools were first recorded.

Putting it right

The Trust wrote to Mr and Mrs T to acknowledge the failings identified by this report and apologised for the impact these had on Mrs M and her family. It also completed an action plan to address the failings identified and prevent a recurrence.

Organisation(s) we investigated

West Hertfordshire Hospitals NHS Trust

Location

Hertfordshire

Region

East

Summary 927/March 2015

Doctor failed to give pain relief to man approaching end of life and to tell him or his family that he might die soon

Mrs Q complained that a doctor who visited Mr Q at home did not give him pain-relief or refer him to hospital, although the doctor appreciated that Mr Q was nearing the end of his life.

What happened

Mr Q had recently received treatment for lung cancer. An out-of-hours doctor visited Mr Q at home because he was in pain and had difficulty breathing. The doctor was unable to get a blood pressure reading for Mr Q and did not give any pain relief to Mr Q because he wasn't sure what medications he had in his kit. Instead, he gave Mr Q's partner, Mrs Q, a prescription for painkillers to get at a local out-of-hours chemist.

The doctor then told Mrs Q that Mr Q was 'very poorly' when he actually meant that Mr Q was approaching the end of his life and might die soon. Mrs Q did not understand the seriousness of her partner's condition and went to the chemist to collect the prescription. Sadly Mr Q died before she returned.

Mrs Q said the out-of-hours doctor left Mr Q in pain, and that he might have survived if the doctor had referred him to hospital.

What we found

We partly upheld this complaint. The out-of-hours doctor should have known what medications he had available. He also should not have left Mr Q in pain without administering some pain relief. Although the care given by the out-of-hours doctor amounted to service failure, there was no evidence that the lack of pain relief caused Mr Q's death.

The out-of-hours doctor should have clearly communicated to Mrs Q that Mr Q was dying. He also should have checked whether Mr Q wanted to go to hospital to end his life there.

Alternative action would not have saved or prolonged Mr Q's life but it would have made the tragic events more bearable for Mrs Q who suffered uncertainty and distress.

Putting it right

The out-of-hours service acknowledged and apologised for its failings and paid Mrs Q £250.

Organisation(s) we investigated

GTD Harmony Ltd

Location

Greater Manchester

Region

North West

Summary 928/March 2015

Son was unhappy about NHS decision not to fund father's care

Mr A said the Clinical Commissioning Group (CCG) refused to carry out a retrospective review of the entitlement of his late father, Mr E, to NHS continuing care between early spring 2004 and the end of 2008. He was concerned that this left his family financially disadvantaged because they had to fund the care themselves.

What happened

Mr E lived in a care home from beginning of 1997 until he died in late 2008. During his stay, he was assessed for NHS continuing healthcare funding in autumn 2004, early spring 2007, summer 2007 and again in mid-autumn 2008. Following these assessments he was awarded differing levels of care funding.

Following the assessment in autumn 2004 he was classified as eligible for high band Registered Nursing Care Contribution. After he was assessed again in summer 2007, Mr E was classified as eligible for medium band Registered Nursing Care Contribution. Following the final assessment in mid-autumn 2008 he was classified as eligible for full NHS continuing healthcare.

Mr A disputed the level of care funding awarded to his father during this period and believed him to be eligible for full NHS continuing healthcare funding for the entire period from early spring 2004 to the end of 2008.

What we found

We partly upheld this complaint. The CCG explained that Mr E was assessed for NHS continuing healthcare on each occasion. However, there was a 30-month gap between the first and second assessments where there was no record of an NHS continuing healthcare assessment taking place. There was no evidence to explain why an assessment was not carried out at any time between 2005 and 2006.

During the assessments in 2007 and 2008, Mr E's next of kin and power of attorney at the time, Mrs F, was present for the assessments. The CCG informed Mrs F of the results and gave her the opportunity to comment on the findings. The CCG also advised Mr E and his family of their right to appeal at that time but they made no appeal.

All the assessments clearly indicated that the CCG was considering continuing healthcare funding for Mr E. The CCG also made Mr E's representative and next of kin aware of the result of the assessments and gave her the opportunity to raise concerns if she wasn't happy with them. There was no evidence that the representative and next of kin raised any objections and we decided that the decision of the CCG not to review the periods covered by these assessments was appropriate.

There was no evidence that any assessments of Mr E's eligibility for NHS continuing healthcare were carried out in the 30 months between autumn 2004 and spring 2007, which is clearly an unassessed period of care. This was a failing by the Primary Care Trust (subsequently replaced by the CCG in 2013).

Putting it right

The CCG agreed to consider reviewing Mr E's eligibility for NHS continuing healthcare for the period of autumn 2004 to early spring 2007.

Organisation(s) we investigated

Warwickshire North Clinical Commissioning Group (CCG)

Location

Warwickshire

Region

West Midlands

Summary 929/March 2015

Practice failed to properly consider patient's requests for adjustments under the *Equality Act*

The Practice did not consider Mr D's requests for adjustments in line with the *Equality Act 2010* and its communication about parts of this was poor, which had an emotional impact on him.

What happened

Mr D was newly registered with the Practice. He was autistic and noise, lights and other people affected him, which made it difficult for him to sit in a waiting room. He also found building relationships with people difficult and this could take time.

Mr D asked for two adjustments to be made. The first was at the Practice for appointments, after letting reception staff know he had arrived, he wanted to be able to wait in his car until the GP was available. He said staff could call him on his mobile to let him know to come in.

He secondly wanted to be able to see the same GP where possible, even if this meant waiting a day or two until that named GP was available. This would have been a slight adjustment to the Practice's appointment policy (call for a same day appointment with whichever GP is available or pre-book an appointment three to four weeks ahead). Mr D accepted there would be occasions where this was simply not possible, such as if the named GP was on leave.

The Practice refused to make either adjustment.

What we found

The Practice was obliged to consider Mr D's requests for adjustments in line with the *Equality Act 2010*. The Equality Act Codes of Practice expect an organisation to consider certain criteria when it decides whether or not it can agree to adjustment requests. The Practice did not consider the requests against these criteria and it did not have a clear process for doing this.

A member of Practice staff had agreed to the first adjustment before she had authorisation to do so. The Practice also failed to properly understand what Mr D was asking for regarding the second adjustment.

The Practice's failure to look at Mr D's requests in the way it should have caused him anger, sadness and frustration.

Putting it right

The Practice acknowledged the failings and apologised to Mr D for the emotional impact they had on him.

The Practice paid Mr D £200 to recognise the emotional impact of the failings.

The Practice also developed a standard procedure for considering requests for adjustments in line with the *Equality Act 2010*. It sent this to Mr D and explained how it would be implemented and monitored.

In addition to our recommendations, two of the Practice partners received equality and diversity training, and the Practice also put in place a new, up-to-date equality and diversity policy.

We considered the Practice had fully acknowledged what had gone wrong and demonstrated serious commitment to putting this right.

Under embargo until 00.01 Thursday, 22 October 2015

Organisation(s) we investigated

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 930/March 2015

Clinical care of an older man was appropriate but he was not given important information about his condition

Mrs T complained that failings in her husband's care and treatment over a number of years resulted in his death.

What happened

Mr T was in his late seventies. In 2008 he had a heart attack and was taken to hospital. Doctors started treatment for his heart attack and booked him for a diagnostic test called an angiogram. The test did not take place because Mr T developed diarrhoea and because he later discharged himself from the hospital against the advice of his doctors. Over the following months, Mr T was booked two more times to have an angiogram, but on each occasion he cancelled the test.

In 2009 Mr T was referred by his GP to the hospital with symptoms of itching, weight loss and loss of appetite. Doctors investigated Mr T's symptoms and inserted a stent, an expandable tube, into the common bile duct (a part of his digestive system). They planned to repeat the procedure and replace the stent two months later. However, they gave Mr T a patient information leaflet that said the stent could 'remain in place permanently'. And Mr T therefore wrote to his doctors to say that he did not want to undergo the repeat procedure.

In late 2010 Mr T started having abdominal discomfort and his GP referred him back to the hospital. The GP made an appointment for Mr T, but he cancelled it. His GP referred him again to the hospital in 2011 and a scan showed multiple liver abscesses and multiple lesions on his spleen. Mr T was admitted to hospital and treatment and investigations were started. He was later transferred to another hospital, run by a different trust, but he died.

What we found

We partly upheld this complaint. After Mr T's heart attack in 2008, his doctors had acted in line with recognised standards and good practice. They had also taken reasonable decisions about his further care and treatment, given that Mr T seemed reluctant to undergo the investigations and treatment they planned for him.

In spring 2009 doctors had assessed Mr T's condition in line with the General Medical Council's Good Medical Practice and investigated his symptoms in line with guidance by the British Society of Gastroenterologists. Doctors had acted in line with established good practice and made decisions about Mr T's further care and treatment that were based on all relevant considerations. However, the patient information leaflet Mr T was given to read in 2009 was wrong. The stent could not be left in place permanently, but needed to be replaced every three to six months. And when Mr T wrote to his doctors about this, they did not correct his understanding or tell him about the risks if the stent was not changed or removed.

Due to these failings in communication, Mr T was denied the opportunity to make a fully informed choice and to receive care and treatment that might have saved his life.

Mrs T's distress at her husband's death was worsened by the uncertainty of never knowing whether Mr T might have survived if doctors had given him all the information he needed to know about his stent.

Putting it right

The Trust apologised to Mrs T and paid her £750 as an acknowledgement of the added distress it had caused her. It also put together an action plan that showed learning from its mistakes so they would not be repeated. This included changes to the patient information leaflet.

Organisation(s) we investigated

Norfolk and Norwich University Hospitals NHS Foundation Trust

Location

Norfolk

Region

East

Summary 931/March 2015

Hospital staff made multiple failings in assessing, investigating and monitoring a woman's condition

Mrs J's family complained that during her final stay in hospital, Trust staff did not monitor Mrs J's food and drink intake. There was poor communication between Trust staff and as a result, no clear diagnosis of Mrs J's condition was ever reached before she died.

What happened

Mrs J was in her eighties and lived independently in her own home with support from her two daughters. She required regular anticlotting medication and also pain relief because of a longstanding medical condition in her hip that affected her mobility. Her local GP Practice gave her treatment.

Mrs J started to experience episodes of confusion and her mobility deteriorated. At the request of Mrs J's family, doctors from the Practice often carried out home visits. However, at no point did the doctors feel that Mrs J lacked capacity to make decisions about her care. The Practice arranged carers to help Mrs J move around her home but unfortunately, her condition continued to deteriorate and doctors from the Practice along with Mrs J's care manager, strongly encouraged her to consider going into hospital. Mrs J was admitted to a community hospital (the Trust).

During Mrs J's stay at the Trust, nurses failed to carry out appropriate nutritional risk assessments or refer her to a dietician. Even though staff made some effort to monitor Mrs J's fluid intake, these records were inadequately completed. The bowel care provided for Mrs J was also poor. There was lack of communication between nurses, physiotherapists and occupational therapists regarding Mrs J's care, particularly in relation to her mobility.

Although staff noted that Mrs J's recent medical history included episodes of confusion, they did not arrange a scan of Mrs J's head to investigate whether her confusion could be the result of bleeding in her brain. After Mrs J's family raised concerns that their mother might have had a stroke, doctors agreed to arrange a scan of her head. But, at that point, Mrs J's condition had deteriorated to the point that she was too unwell to undergo the scan. Mrs J's condition continued to deteriorate and she died with her family by her side.

What we found

We partly upheld this complaint. The Practice gave Mrs J appropriate care and responded adequately to her complaint. However, in relation to the Trust, we concluded that the failure to carry out a scan of Mrs J's head at an early stage meant that she missed any opportunity for treatment that there might have been. She also missed having a definite diagnosis that might have informed a decision to go back home. In addition, we concluded that Mrs J's family had not had the benefit of a diagnosis and we agreed with her family that doctors did not listen to them as they should have done.

There were failings in the way that nurses, physiotherapists and occupational therapists communicated with each other regarding Mrs J's mobility. This was compounded by a poor assessment of her condition by occupational therapy staff. As a result, nurses, physiotherapists and occupational therapists did not fully establish what support should be provided to help her mobilise. This meant that Mrs J experienced unnecessary suffering and distress when moving and being moved. We acknowledged that witnessing this also caused her family distress. This could have been avoided if those providing care for Mrs J had communicated appropriately with each other. We concluded that these failures caused both Mrs J and her family unnecessary suffering and distress during her final admission.

Putting it right

The Trust acknowledged and apologised for its failings and put together an action plan explaining how it would ensure that the same situation would not happen again. It also paid Mrs J's family £1,500 compensation for the distress and suffering they experienced as a result of the poor care given to their mother.

Organisation(s) we investigated

Worcestershire Health and Care NHS Trust

A GP practice

Location

Worcestershire

Region

West Midlands

Summary 932/March 2015

Clinical care of an older man was appropriate

Mrs M complained that failings in her husband's care and treatment resulted in his death.

What happened

Mr M was in his late seventies. In 2011 he was admitted to the Trust's hospital from another hospital for continued investigation. He suffered from liver abscesses and possible strictures in his biliary duct (tubes to carry bile) that were related to either infection from a stent (a tube previously inserted to keep his biliary duct open) or a tumour. He also had fluid in his abdomen.

After Mr M had been in the hospital for about two weeks he wanted to go home and his family talked to doctors about outpatient, rather than inpatient, treatment for him. His doctors had misgivings about outpatient treatment because this would mean that they could not monitor or treat Mr M in a way that they wanted to. Doctors wanted to perform a procedure to replace Mr M's stent, but when they talked to him about this he refused to have it done without a general anaesthetic. So doctors discharged Mr M home with oral antibiotics.

Doctors continued to review Mr M in outpatients and when his condition deteriorated (partly as a result of a side effect of his antibiotics), he was readmitted. Mr M stayed in hospital for almost a month before he was discharged home again with oral antibiotics. Again there were side effects, so Mr M stopped taking his antibiotics. He died a few days later.

What we found

We did not uphold this complaint. It would have been established good practice to have administered six weeks of intravenous antibiotics. Had this happened, it was likely that Mr M would have recovered from his illness, although this was not certain. However, the reason Mr M did not receive continuous intravenous antibiotics was because he had insisted on leaving the hospital. Mrs M argued that she and her family did not know how important it was that her husband should remain in hospital. We found that doctors' communication with Mr M and his family had been frequent and clear, and that on occasion Mr M had not followed their advice or had refused treatment or procedures.

Mrs M also said that her husband should have been fed intravenously, but the advice we received was that this would not have been appropriate. Mr M needed to eat normally or agree to having a nasogastric tube (a tube inserted through the nose to allow him to be fed directly into his stomach) inserted, but he refused this.

Doctors in the hospital had assessed Mr M's condition and arranged the investigations and treatment he needed in line with the General Medical Council's *Good Medical Practice*. It would clearly have been better if Mr M had remained in the hospital, but given his apparent dislike of hospitals, his refusal to eat and his desire to leave hospital, the decisions the doctors made about his care and treatment were based on all relevant considerations.

Organisation(s) we investigated

Cambridge University Hospitals NHS Foundation Trust

Location

Cambridgeshire

Region

East

Summary 933/March 2015

Failings in mental health assessment

Mr Q complained about his assessment and discharge from hospital in winter 2013, where he had been admitted after attempting to take his own life. He complained that the two Trusts concluded that he was treated appropriately without sufficient evidence to support this view.

What happened

In winter 2013 Mr Q took an overdose of painkillers combined with alcohol. He contacted a friend and was taken by ambulance to the first Trust. His mother joined him in hospital and was present at his initial assessment. That evening, Mr Q was assessed as having a suicide risk score of 8, which put him at high risk and probably requiring hospital admission. Mr Q had blood tests and, according to his mother, he was told by a doctor that he would be assessed by the mental health crisis team from the second Trust and monitored in hospital overnight. Mr Q was transferred from A&E to the acute assessment centre (AAC) where his mother said her contact details, including her mobile telephone number, were recorded.

Later that night, Mr Q was assessed by a mental health team from the second Trust. The mental health team recorded that, by the time of the assessment, Mr Q had no suicidal intent and that he had calmed down and sobered up. A psychotherapy referral was agreed. A suicide risk score of 5 was calculated, indicating he was possibly fit for discharge. According to nursing notes, Mr Q "*had no mobile phone with him and no contact numbers available. He wanted to leave and walk to his friend who lives locally to get his car and his mobile phone*".

Mr Q was discharged that evening to make his own way to a temporary residence for follow-up community care.

Mr Q's mother said that at around midnight she was called by Mr Q's father, who told her that Mr Q had been discharged against his will. He had no money, phone or transport, and had knocked on a stranger's door in order to telephone his father's house. His father's partner took the call. Mr Q had forgotten his mother's mobile number.

In early 2014, Mr Q's mother complained to the Trust on his behalf about his assessment and discharge. She said that he had been forced to leave hospital when he was vulnerable and at risk yet she had been reassured that he would be kept in overnight. She asked why nobody had called her to let her know.

The Trust said that they took appropriate physical and mental health assessments and these indicated that Mr Q had capacity and was fit for discharge. He had told the assessing mental health clinician that he would be staying with a friend when he left hospital, and nursing records confirmed that he wanted to leave and walk to a friend's house nearby. He had been told that he could stay in hospital overnight if he wished. The Trust explained that Mr Q's contact and next of kin details had not been updated. It apologised for this failing.

Mr Q denied that he was discharged willingly.

What we found

We found no failings in relation to the discharge decision. However, we found failings in Mr Q's mental health assessment by the second Trust. The documentation does not provide evidence of a detailed assessment and therefore the decision that Mr Q was psychologically fit for discharge was not based on adequate evidence.

We were unable to conclude that Mr Q was psychologically unfit for discharge. His return for follow-up treatment a few days later supported the view that he did not need to stay in hospital. However, Mr Q and his family were not reassured that the discharge decision was as thorough as it should have been.

Putting it right

The second Trust wrote to Mr Q acknowledging the failings identified by our investigation and apologised for the impact these had on him. It also explained to Mr Q what action it had taken to address the failings we identified.

Organisation(s) we investigated

Burton Hospitals NHS Foundation Trust (first Trust)

South Staffordshire and Shropshire Healthcare NHS Foundation Trust (second Trust)

Location

Staffordshire

Region

West Midlands

Summary 934/March 2015

Trust failed to provide appropriate care, treatment and nutritional support to woman with learning disabilities

Mrs G complained that the Trust did not give her daughter, Miss N, appropriate care and treatment during her hospital stay in 2012. She also complained about inadequate communication by clinical staff and a failure to consider Miss N's mental capacity. Mrs G said failings in these aspects of care led to Miss N's death.

What happened

Miss N had learning disabilities and epilepsy. In autumn 2011 she had surgery at the Trust's hospital for a twisted bowel. Miss N was briefly admitted to the hospital in early 2012 on three occasions with repeated vomiting. Each time she was treated for constipation and sent home. Mrs G said that the Trust delayed diagnosing Miss N's bowel condition. Later in the month, Miss N was still vomiting and was admitted again. During the admission Miss N developed aspiration pneumonia (caused by inhalation of food, vomit or other foreign matter into the lungs) and died.

What we found

We partly upheld Mrs G's complaint. Although Miss N's death was not avoidable, we found there were failings in her care and treatment. These included: delays in assessing and testing Miss N's gastroenterological symptoms; delays in giving nutrition by percutaneous endoscopic gastrostomy (PEG – feeding via a tube inserted into the stomach) and no consideration of alternative routes of nutrition; there were no tests to exclude bowel obstruction before the PEG was inserted; doctors failed to manage Miss N's epilepsy appropriately; doctors did not communicate adequately with Mrs G about Miss N; mental capacity assessments did not take place and they should have done; and doctors did not act with proper regard for disability discrimination law or Miss N's rights as a person with learning disabilities. These failings led to service failure and injustices to Mrs G and Miss N.

Putting it right

The Trust wrote to Mrs G to acknowledge the service failures and to apologise for the injustices that she and Miss N suffered. It also paid £2,000 compensation to Mrs G. The Trust also prepared an action plan to describe what it had learnt from the failings identified so that they don't happen again.

Organisation(s) we investigated

Royal Free London NHS Foundation Trust

Location

London

Region

Greater London

Summary 935/March 2015

Health and social care organisation did not appropriately plan care and failed to respond to a deterioration in a man's mental health

Mr B's grandmother, Mrs A, complained that the health and social care organisation did not do enough to identify Mr B's needs or respond appropriately when there were signs of his mental health beginning to deteriorate.

What happened

Mr B had Asperger's syndrome and bipolar disorder. He had lived in supported housing since 2012. He had a history of mental health problems and was receiving support from the mental health services for several years. At the beginning of 2013 Mr B's mental health deteriorated. During this time he left hospital and was later detained by the police. In spring of that year, he damaged property, and staff at the supported housing project called the police. After a short period at the police station, the police transferred him to a psychiatric unit. Mr B asked to leave hospital within a few hours of arrival. He was not detained under the *Mental Health Act 1983* at that time. Mr B left the ward and was found in the community. The police took him back to the psychiatric unit and he was then detained under the *Mental Health Act 1983*.

What we found

The care planning fell short of national standards, which require care reviews to involve all professionals working with the patient. The health and social care organisation accepted that there was an undue clinical focus in Mr B's early care plans. However, in relation to Mr B's Asperger's syndrome the care planning was appropriate because the health and social care organisation identified Mrs B's specialist needs. The health and social care organisation acted in accordance with the *Autism Act 2009* in commissioning a new specialist support service.

The health and social care organisation missed clear signs in relation to Mr B's deterioration in his mental health. This caused Mr B considerable distress.

Putting it right

The health and social care organisation acknowledged the faults we identified and apologised to Mrs A and Mr B. It also paid £1,000 to Mr B and £500 to Mrs A to reflect their distress.

The health and social care organisation produced an action plan to address the faults identified and minimise the risk of recurrence.

Organisation(s) we investigated

NAViGO Health and Social Care Community Interest Company

Location

Lincolnshire

Region

East Midlands

Summary 936/March 2015

Patient may have lived longer or in less discomfort but for missed opportunities

Mrs R's daughters complained that the GP Practice and the hospital missed opportunities to detect and treat their mother's cancer earlier, the hospital gave her poor care on the cancer ward, and were also unhappy with the Practice's and the Trust's responses to their complaint.

What happened

Mrs R's GP referred her to a gastroenterologist to investigate symptoms suggesting bowel cancer. Mrs R had a number of tests in mid-2011, including a CT scan of her chest, abdomen and pelvis. The gastroenterologist concluded there was no sign of cancer.

In late 2011 Mrs R went to the emergency department at her local hospital with pain associated with a urinary stone. Doctors arranged a CT scan of Mrs R's kidneys, ureters (the tubes that carry urine from the kidneys to the bladder), and bladder. This showed a possible small stone in Mrs R's ureter, and an abnormality in the bowel, but the bowel abnormality was not identified.

Over the next seven months Mrs R repeatedly visited her GP and the emergency department with various symptoms. She also had a number of urological investigations and treatments. In July 2012 urologists referred her for another CT scan of her abdomen and pelvis. This showed bowel cancer. Mrs R was subsequently twice admitted to the hospital's cancer ward. However, she suffered a perforated bowel on her second admission, and sadly died.

What we found

We partly upheld this complaint. The GP Practice had provided appropriate care and treatment and had responded reasonably to the complaint.

The Trust provided appropriate care and treatment for Mrs R on the cancer ward and where there had been shortcomings, it had responded appropriately. However, there was service failure in that the Trust should have arranged further investigations to exclude the possibility of cancer in mid 2011, and also identified and acted on an abnormality on a CT scan in late 2011, but did not do so. Mrs R may have lived longer, or in less discomfort but for those missed opportunities to further investigate her symptoms. This caused her family uncertainty and distress. There were also some shortcomings in the Trust's complaint responses, but we decided these did not amount to maladministration.

Putting it right

The Trust agreed to apologise to Mrs R's daughters, and it paid them £1,000 (to be shared equally between them). It also prepared an action plan setting out what it had done/ would do to learn the lessons from this complaint.

Organisation(s) we investigated

Heatherwood and Wexham Park Hospitals NHS Foundation Trust

A GP practice

Location

Slough

Region

South East

Under embargo until 00.01 Thursday, 22 October 2015

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