Parliamentary and Health Service Ombudsman

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

December 2014 and January 2015

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

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

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

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

July 2015

Complaints about UK government departments and other UK public organisations

Summary 620/December 2014

Pensioner paid too much tax and HMRC refused to refund it

Mr D overpaid tax for nearly 20 years during his retirement until he died.

What happened

Mr D was entitled to an age-related allowance but this was not added to his pension's tax code, meaning that he paid more tax than he needed to.

After Mr D's death, his son Mr C, who was the executor of his estate, found out about the overpayment. He asked HM Revenue & Customs (HMRC) to refund it to Mr D's estate. HMRC refunded the tax overpaid for the previous five years in line with tax law's statutory deadline for overpayment claims. However, it said it could not refund most of the overpayment, which was before that time, because the claim was out of time.

Mr C asked HMRC to decide whether it had made an error that caused the overpayment and to consider repaying earlier years' tax. He felt that if HMRC had caused the overpayment, it would be able to consider refunding the tax overpaid. HMRC said that it had no evidence it had made an error and therefore it could not refund the remaining overpaid tax. It also said that, in order to add age-related allowances to a taxpayer's pension code, the taxpayer must make a claim for it. This is because HMRC does not add those allowances automatically unless asked to do so. It also has no legal obligation to do so.

What we found

We did not uphold this complaint. HMRC's explanation and decision about the overpayment were correct. There was no evidence that Mr D had made a claim for age-related allowances or returned a pension form while he was alive. Because of the passage of time and HMRC's data retention policy, it was now impossible for us to say that HMRC had made an error that caused the overpayment. We concluded that, without evidence of error by HMRC, it was correct to say that the tax law must prevail and the refund could not be given.

HMRC's complaint handler, the Adjudicator's Office, had investigated the complaint before us. The Adjudicator found that, although HMRC's decision had been correct, it had not handled Mr C's enquiries well. HMRC had delayed responding to him and had sent confusing letters that made the issue drag on for an unnecessary length of time and caused distress. The Adjudicator recommended that HMRC apologise to Mr C and pay him a £125 consolatory payment. We agreed with this recommendation and considered that it was in line with what we would have recommended. We therefore had no grounds to make further recommendations.

Organisation(s) we investigated

Adjudicator's Office

HM Revenue & Customs (HMRC)

Summary 621/December 2014

UK Visas and Immigration delayed deciding couple's request to stay in the UK with their family

Mr G complained that UK Visas and Immigration (UKVI) delayed dealing with the application he and his wife had made to stay in the UK.

What happened

In 1999 Mr and Mrs G arrived in the UK as visitors. However, in 2000 they applied to stay because they were seeking asylum and they also wished to stay as dependents of their son, who was already settled in the UK.

By spring 2003 UKVI had refused both of those applications.

Mr and Mrs G stayed in the UK as overstayers (people who are subject to immigration control who remain in the UK beyond the expiry of their leave to remain). Then, in 2009 and 2010, they asked UKVI to reconsider their asylum claim. UKVI started work on the case in 2010 but instead of making a decision on it, it put the case in its archive and did not finish it until early 2014. UKVI granted Mr and Mrs G 30 months' discretionary leave to stay in the UK because they had lived in the UK for a long time (14 years by then).

Mr and Mrs G say they have been distressed by the delay as their immigration status has been unresolved since 1999.

What we found

We partly upheld this complaint. When Mr and Mrs G gave UKVI the information it asked for, UKVI did not properly record that it had received it. UKVI should have tried to contact Mr and Mrs G through their representatives before sending their case to the archive, but it did not. When Mr and Mrs G twice asked a UKVI advice worker at their local temple what was happening to their case, UKVI took no action. It was only when we intervened that it considered their case.

When UKVI looked at Mr and Mrs G's case, it mistakenly only decided Mr G's application. It told Mrs G she would have to apply separately. This delayed Mrs G's case by a further month. In total, Mr and Mrs G had to wait two years and seven months longer than necessary for their application to be decided.

Putting it right

UKVI apologised to Mr and Mrs G for not deciding their case sooner (it should have done this by summer 2011), and for not responding to Mr and Mrs G's approaches through a UKVI advice worker and through their own representatives.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 622/December 2014

UK Visas and Immigration did not did not consider two laws when making an immigration decision

Mr S complained that UK Visas and Immigration (UKVI) did not take his personal circumstances into account when it refused him leave to remain in the UK in spring 2013. In particular, it did not take his family life into account.

What happened

Mr S arrived in the UK in 2009 as a student but overstayed his visa. His later applications for leave to remain were unsuccessful but he made a third application in early 2012. In the covering letter, his solicitors explained that Mr S had proposed to his partner (now wife), who had settled in the UK, in early spring 2011.

In late 2012, the solicitors told Mr S's MP (but not UKVI) that Mr S and his wife were expecting a child in summer 2013.

In spring 2013, UKVI refused Mr S's application because he had only been living with his partner for four months, which was not enough for immigration purposes.

Mr S's solicitors also said that UKVI failed to consider Mr S's case under two laws, first against the Immigration Rules (pieces of legislation that make up the UK's immigration law), and then under Article 8 of the *European Convention on Human Rights,* which says there has to be respect for a person's private and family life.

What we found

We partly upheld this complaint. UKVI's explanations about Mr S's case were reasonable in that he had not been living with his partner for more than two years at the time of his application. This did not accord with the Immigration Rules. We also accepted UKVI's explanation that it could not consider Mr S as a fiancé under the Immigration Rules because he had not originally entered the UK as a partner/fiancé.

Having considered information from the solicitors and seen Mr S's Home Office file, we found no evidence that UKVI had been told of Mr S's impending fatherhood before it made its decision in spring 2013. Therefore, we did not consider it was reasonable to expect UKVI to take this into account in its decision.

UKVI told us that it was its practice, as it was bound by law, to consider whether there was reason to grant leave to remain under Article 8 of the *European Convention on Human Rights*, separately from its consideration under the Immigration Rules. However, there was no evidence to show that UKVI considered Mr S's case in this way.

The reason that UKVI reconsidered Mr S's case (in part) was a technicality: UKVI could not demonstrate that it had considered Article 8 separately from the Immigration Rules, which it is legally obliged to do.

Putting it right

UKVI apologised for its incomplete handling of Mr S's case and reconsidered it, taking into account Article 8 of the *European Convention on Human Rights*. This led to UKVI granting Mr S leave to remain until December 2017. We also said it would be open to Mr S to ask UKVI for compensation following its decision on the outstanding part of the application.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 623/December 2014

Woman's email address sent to abusive ex-partner

Ms L complained to us about a number of mistakes the Children and Family Court Advisory and Support Service (Cafcass) had made in family court proceedings about her daughter. She felt these mistakes had unfairly influenced proceedings, and had allowed her expartner to be given contact with their daughter.

What happened

Ms L's ex-partner had abused her. During a court hearing, a judge ordered that he should attend a domestic violence prevention programme with a specific provider. Cafcass did not follow the court order and referred Ms L's expartner to a programme with another provider, one which was his preferred choice.

Ms L complained that Cafcass's family court adviser was late to the court hearing, treated her ex-partner favourably and referred him to the wrong programme. She also said that Cafcass gave her ex-partner her email address although contact with him was extremely stressful to her, given the history of their relationship.

She said that Cafcass's mistakes had led to her ex-partner being awarded contact with her daughter and she had spent thousands of pounds challenging that decision.

Cafcass admitted that it had made some mistakes but it did not recognise the impact of them.

What we found

We partly upheld this complaint. Cafcass made a number of significant mistakes in this case that made an already difficult time more emotionally demanding for Ms L.

We did not find that its mistakes led to her ex-partner getting contact with her daughter, although we understood why she had felt as if she was at a disadvantage.

Putting it right

Cafcass apologised to Ms L that the family court adviser was late to the hearing.

It paid her £500 in recognition of the unnecessary distress she had been caused by its failure to comply with the court's order about the domestic violence prevention programme. It paid a further £500 in recognition of the anxiety it had caused when it disclosed her email address. It also took steps to make sure that staff do not disclose personal details.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 624/December 2014

Environment Agency took too long to act against odour and noise pollution

The Environment Agency's eleven-month delay in taking enforcement action against odour and noise pollution caused a family unnecessary stress and frustration.

What happened

The Environment Agency issued an environmental permit to a waste recycling facility that processed several different types of waste, including household waste.

Mrs K began making complaints about odour and noise from the site a few months after it started to operate. At the same time, the Environment Agency recorded a breach of the environmental permit.

Over the next eight months, the Environment Agency recorded further breaches. It gave the site operator guidance and advice about how it should improve matters to prevent pollution, but this was not successful.

Over the following eleven months, the Environment Agency recorded six more breaches and noted the site owner was not complying with its guidance. During this time, Mrs K's family made a number of complaints about odour and noise pollution, but the Environment Agency took no action for some time.

What we found

The Environment Agency should have taken stronger enforcement action eight months after the site became operational. Instead, it waited a further eleven months before taking any action, although the recycling facility failed to follow its advice or to improve.

The Environment Agency's delay allowed the site to continue breaching its environmental permit. This prolonged the odour and noise pollution and led to more complaints.

Mrs K and her family were caused unnecessary frustration, upset and distress as a result of the Environment Agency's delayed enforcement action.

Putting it right

The Environment Agency apologised to Mrs K's family and paid them £1,500 compensation for the impact of its delay in taking enforcement action.

Organisation(s) we investigated

Environment Agency

Summary 625/December 2014

Delayed decision on failed asylum seeker's further submissions

UK Visas and Immigration (UKVI) took too long to make a decision on Mr A's case and its communication with him was poor.

What happened

Mr A came to the UK in 2001. He was refused asylum but remained in the UK, where he met his partner, also a failed asylum seeker. Their two children were born in the UK. From 2007, Mr A contacted UKVI to ask it to reconsider his case. In spring 2012 UKVI refused him permission to stay in the UK. Mr A made further submissions in autumn 2012, but he and his family did not get a decision that they could stay until early 2014.

What we found

UKVI should have made a decision on Mr A's first submission by summer 2011 but did not do so until spring 2012. It did not record the reasons for its decision, which left Mr A without confidence in the decision-making process.

UKVI should then have made a further decision on his additional submissions by the end of 2012 but it did not do so until early 2014. UKVI communicated poorly with Mr A and took longer than it should have done to consider his request for permission to work. The delay in deciding his immigration status caused Mr A and his family frustration, inconvenience and uncertainty.

Putting it right

UKVI apologised to Mr A and paid him £150 for the injustice we identified.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 626/December 2014

Information Commissioner's Office was at fault in complaint handling

The Information Commissioner's Office (ICO) decided that it would not uphold Ms B's complaint about the *Data Protection Act*. However, it did not tell her that she could ask it to review that decision.

What happened

Ms B complained to ICO about her energy company. She said that it asked her for her date of birth to take a bill payment, and she was unwilling to give it. ICO decided that the energy company had probably complied with the *Data Protection Act*. Ms B was dissatisfied with that decision, and so complained to us.

What we found

We partly upheld this complaint. When we told ICO that we were going to investigate this case, it acknowledged that it had not told Ms B that she could ask it to review its decision. ICO therefore reviewed that decision, and upheld Ms B's complaint. It then apologised to Ms B for its mistake.

ICO's decisions about the energy company were reasonable, although Ms B was put to some inconvenience by its failure to tell her that she could review its decision. ICO's apology was an appropriate remedy for that inconvenience.

Putting it right

We made no recommendations in this case.

Organisation(s) we investigated

Information Commissioner's Office (ICO)

Summary 627/December 2014

UKVI failed to record that it had received complaint, or respond in good time

Mr L said that UK Visas and Immigration (UKVI) did not recognise that his foreign birth certificate showed his right to work in the UK, and did not acknowledge or respond to his complaint.

What happened

Mr L complained that, although he was a British citizen, UKVI told his prospective employer that his birth certificate did not show his right to work in the UK. Mr L said this prevented him from taking paid employment. In addition, UKVI denied receiving correspondence from Mr L and also sent a letter to his MP that did not arrive. Mr L asked for compensation for a loss of earnings.

What we found

We partly upheld this complaint. UKVI failed to record that it had received Mr L's complaint or respond to him in a reasonable time. This caused Mr L frustration, and delayed information he needed.

However, there was no evidence of contact between Mr L's prospective employer and UKVI. UKVI correctly said that Mr L's birth certificate did not demonstrate his right to work in the UK because it was not issued in the UK.

UKVI had sent a response to Mr L's MP, but the MP's office had not received this.

Putting it right

UKVI apologised for the frustration it had caused Mr L.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 628/December 2014

HM Passport Office did not fully correct mistake

Ms J complained that HM Passport Office mishandled both her son's passport application and her subsequent complaint about this.

What happened

In spring 2006 HM Passport Office issued Ms J a passport for her young son, valid for five years, without first making sure he was registered as a British citizen.

When Ms J applied to renew her son's passport in 2011, HM Passport Office realised its mistake and rightly refused the application. HM Passport Office agreed to remedy its mistake.

It told Ms J to apply to UK Visas and Immigration (UKVI) for her son's registration as a British citizen and said it would refund the cost.

Ms J could not afford to pay the cost of her son's registration in advance and then claim a refund of the increased cost, because it was a large amount. As a result, Ms J made a further unsuccessful passport application for her son using his father's citizenship.

What we found

There was no evidence of error in HM Passport Office's handling of Ms J's son's 2011 passport application. But there was error in how it handled her subsequent complaint.

HM Passport Office should have considered Ms J's circumstances and not assumed that she could afford to pay UKVI the full cost of her son's registration application before she asked it for a refund.

Putting it right

HM Passport Office arranged to pay £469 directly to UKVI. This is the difference between the cost of registering a child as a British citizen in 2006 and in 2014. It also agreed to give Ms J contact details of a UKVI officer who could deal with her application to register her son as a British citizen.

Organisation(s) we investigated

HM Passport Office

Summary 629/December 2014

Woman worried by factual errors in report

A report from the Children and Family Court Advisory and Support Service (Cafcass) had several factual errors about Ms T and her partner. Cafcass's complaint handling did not identify the errors.

What happened

Ms T complained about the service she received from a Cafcass officer. She also said that a report contained incorrect information about her and her current partner. Ms T felt the officer may have had a personal reason for disliking her partner. Ms T complained to Cafcass, but its review of her complaint did not show the factual errors.

What we found

We partly upheld this complaint. The Cafcass officer had misinterpreted some information another organisation had given her. This created some factual errors in the officer's report. The level of accuracy fell far below the expected standard.

Cafcass's complaint handling did not acknowledge these errors and missed the opportunity to resolve the matter at an earlier stage. Its response also did not fully address Ms T's concerns that the officer might know a person from her partner's past. This had caused a personal issue with her partner.

While we found no evidence to support Ms T's concerns, Cafcass's response on this point could have been clearer.

While Ms T claimed that Cafcass's errors had exposed her and her partner to a risk of harassment, which caused her to relocate, there was no evidence to support this. However, Cafcass's errors had been unhelpful and upsetting to Ms T.

Putting it right

Cafcass apologised to Ms T for the factual errors in the report and for its complaint handling.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 630/December 2014

Wrong information on website caused farmer significant loss

A farmer got incorrect information from the Department for Environment, Food and Rural Affairs (Defra), but Defra did not consider the financial and other effects its error had on him and his business.

What happened

Mr W, a dairy farmer, applied for an exemption to a European Union regulation that limited the amount of nitrates (which can be a source of pollution) in manure that is spread on land. He did this via Defra's website.

This was the second year Mr W had applied for the exemption, but this time (in 2011) Defra's information about the deadline for applications was wrong, and so he missed the deadline. Because of this, Mr W was not able to get the exemption he needed.

Mr W took immediate steps once he realised that without the exemption, he was breaking the law. He told us he had to either kill or sell a large amount of livestock and reduce the quality of feed to his cows.

He complained to Defra that his business had suffered significant losses because of its error and he was experiencing continued repercussions.

Defra considered his complaint and apologised for its mistake but told him that it would not pay him any compensation.

What we found

Defra had given an incorrect deadline on its website, which was an error. Also, Defra had not dealt properly with Mr W's complaint and had not completed its complaints process. This was because it had not considered that he may have suffered because of its error.

Defra decided to wait for a legal challenge from Mr W or for him to refer his complaint to us. Mr W suffered an injustice from this as Defra did not properly consider his case. It also meant he suffered a significant delay in getting a remedy from Defra.

Putting it right

Defra apologised to Mr W and paid him £500 for the poor handling of his complaint.

It agreed to consider the injustice to Mr W arising from its error, and to appoint an independent lawyer to review the complaint and make recommendations on how it can put things right.

Organisation(s) we investigated

Department for Environment, Food and Rural Affairs (Defra)

Summary 631/December 2014

Food Standards Agency did not explain what it could and could not investigate

Mrs K asked the Food Standards Agency (FSA) to investigate her concerns about a local council. It did, but it did not explain to her the limitations of its remit.

What happened

Mrs K worked for a local council. She was concerned about the qualifications of some of her colleagues who inspected food outlets. When she left the council, Mrs K reported her concerns to the FSA. The FSA carried out an audit of the council, but did not tell Mrs K what it had done. She complained, and the FSA apologised and told her that it would investigate her concerns again. The FSA looked again at the council, but did not tell Mrs K that their remit in doing that was very limited. This meant they could not consider much of what Mrs K raised, and they could not achieve much of what she wanted, including disciplinary action against the staff involved.

Mrs K was unhappy with the outcome of the FSA's investigation.

What we found

We partly upheld this complaint. The FSA should have told Mrs K about its audit of the council. Its apology and the decision to investigate Mrs K's concerns had resolved that fault.

The FSA's investigation of the council was appropriate and we did not uphold that element of Mrs K's complaint. However, the FSA had not told Mrs K what its investigation would look at and what it could achieve. We found this was a fault.

We found failings, but these did not cause Mrs K's claimed injustice.

Putting it right

The FSA apologised to Mrs K for failing to manage her expectations, and for the inconvenience this had caused her.

Organisation(s) we investigated

Food Standards Agency (FSA)

Summary 632/December 2014

UK Visas and Immigration made errors, and delayed decision on asylum seeker's application

UK Visas and Immigration (UKVI) put Ms D's application in storage by mistake. It then delayed making a decision on her application and failed to respond to her request for permission to work.

What happened

Ms D claimed asylum in the UK in 2000 but UKVI refused her claim. In 2008 she asked again for her claim to be considered as she was now settled in the UK and had a partner and child. But UKVI did nothing and put her case into storage in 2011. Despite contact from Ms D and her representatives, UKVI did not take her case out of storage until 2012. It did not make a decision to grant her indefinite leave to remain until spring 2014.

Ms D was granted leave to remain because her husband had leave to remain, and her son had been registered as a British citizen. Ms D had applied for permission to work in autumn 2010 but UKVI did not respond to her request. She applied again in summer 2013 and was granted permission to work.

What we found

We partly upheld this complaint as there were errors in several areas of the complaint. UKVI should have made a decision on Ms D's case by summer 2011 as it had promised. It should not have put Ms D's case in storage. When it took the case out of storage in early 2012, UKVI should have concluded it, but it took over two more years to make a decision. It should have responded to Ms D's request for permission to work in autumn 2010. The records UKVI kept on Ms D's case were poor, with documents and decisions either not recorded or wrongly recorded.

Ms D suffered delay in waiting for her decision. She was denied an opportunity to look for work between autumn 2010 and summer 2011. However, had she received a decision in summer 2011, it is likely she would have been refused, as her husband did not then have leave to remain and her son had not been registered as a British citizen.

Putting it right

UKVI apologised to Ms D and paid her £250 for the delay, anxiety and lack of opportunity to look for work that she experienced as a result of UKVI's errors.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 633/December 2014

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

Mr R complained that three years after he had applied for permission to stay in the UK, UK Visas and Immigration (UKVI) had still not reached a decision.

What happened

In 2003 Mr R came to the UK seeking asylum. UKVI refused this, but Mr R remained in the UK. In spring 2008 Mr R asked UKVI to reconsider his asylum claim using some new evidence. In summer 2010 UKVI again refused Mr R asylum. Later in 2010, Mr R asked UKVI again to reconsider his asylum claim because he had been living with a British partner for over four years and intended to marry.

In autumn 2010 UKVI began work on Mr R's case and made the usual security checks. However, the checks revealed that Mr R was being prosecuted for a minor criminal offence. UKVI stopped working on his case, but in autumn 2010, the prosecution against Mr R was dropped because he was innocent.

Mr R's representatives contacted UKVI, but UKVI did not reply or decide his case. Mr R's MP also contacted UKVI, to no avail. In summer 2013, after the MP had asked us to help, UKVI began work on the case. In winter 2013 UKVI granted Mr R permission to stay in the UK for 30 months.

What we found

UKVI should not have stopped working on Mr R's further submission in winter 2010. It should have repeated its security check each month until the outcome of the prosecution was known. If it had done this, it would have been able to conclude Mr R's application by late 2010 rather than winter 2013. UKVI should also have kept Mr R's representatives informed about his case.

Putting it right

While UKVI delayed deciding Mr R's application, he benefitted from the delay. This was because in 2012 the law changed and UKVI could grant him permission to stay in the UK for 30 months. UKVI apologised for the delay in dealing with Mr R's case and for not replying to the enquiries made by his representatives and his MP.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 634/December 2014

Complaint about unfair refusal of asylum claim and mistreatment at immigration removal centre

Mr Z complained that the Home Office unreasonably refused his asylum claim between 2010 and 2012 and tortured him at an immigration removal centre (IRC) in 2010.

What happened

Before 2010 the Home Office had twice returned Mr Z to another European country because he had already claimed asylum there. In 2010 he came to the UK again.

Mr Z was detained at an IRC and says he was restrained by officers while held in isolation. He claimed that on one occasion he was handcuffed, and at other times he was restrained to keep him at the back of the cell when refusing to co-operate with officers serving him food. He was also restrained when officers cleaned the observation panel which he had covered, making it impossible for officers to see inside the cell.

Mr Z claimed asylum but left the UK before the Home Office decided his case.

In 2011 another European country returned Mr Z to the UK. The Home Office refused his asylum claim and an appeal tribunal upheld its refusal. Mr Z left the UK but another European country returned him here. The Home Office again refused his asylum claim and in September 2012 returned Mr Z to his home country.

In 2012 Mr Z raised his concerns about the IRC with the Home Office. The Home Office should have advised him to complain to the IRC.

What we found

We partly upheld this compliant. We did not find that the Home Office had mishandled Mr Z's asylum claim.

We did not find that Mr Z had been tortured or been treated unreasonably at the IRC in 2010.

We found that the Home Office's failure in 2012 to tell Mr Z to complain to the IRC about his treatment in 2010 amounted to maladministration.

Putting it right

Home Office wrote to Mr Z to apologise for its failure to advise him to complain to the IRC.

Organisation(s) we investigated

The Home Office: UK Visas & Immigration (UKVI) and Immigration Enforcement

Summary 635/January 2015

Vulnerable asylum seeker waited thirteen months for decision from UK Visas and Immigration

Mr N complained about UK Visas and Immigration's (UKVI) delay in deciding his application. He said that he suffered from depression and anxiety and that UKVI's delay caused his health to get worse.

What happened

Mr N came to the UK in 2005 and claimed asylum. The government organisation responsible at that time for immigration rejected his claim. Mr N applied to stay on two further occasions, but was rejected. Eventually he was detained for removal from the UK. UKVI then rejected a third application from Mr N, and again arranged to remove him, but he made a legal challenge to its decision and was released from detention. Shortly afterwards, he began to get asylum support, and UKVI also noted that he suffered from depression and was at risk of self harm. Mr N applied to stay for a fourth time in late summer 2012. But UKVI put his case into storage, and did not look at it for another year. It refused his further request in autumn 2013. Mr N has since applied again to stay in the UK, and has made a further legal challenge, but UKVI has rejected both.

What we found

We partly upheld this complaint. UKVI should have prioritised Mr N's case, not only because he was receiving asylum support but also because he was vulnerable due to his mental health problems. However, UKVI did not give the case priority and extended Mr N's asylum support instead of reaching a decision on his application. As a vulnerable person, Mr N clearly suffered a delay that he should not have done. However, his previous applications had all been rejected and it is likely that if he had received a negative decision earlier, he would anyway have applied again. He has since done so, and has again been rejected. Mr N, therefore, benefited from the delay by being able to remain in the UK during this time, and by continuing to receive public support.

Putting it right

UKVI apologised to Mr N for the delay he suffered when it failed to prioritise his case.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 636/January 2015

Poor administrative handling by courts caused woman loss of over £3,700

Mrs T paid more than £3,700 to a High Court enforcement officer. She then tried to get it back. HM Courts and Tribunals Service (HMCTS) gave conflicting advice and failed to pass a court order to the enforcement officers, so the money was incorrectly given to the company that had brought the claim against her. Mrs T was unable to get the money back.

What happened

A company issued a small claim against Mrs T and she paid more than £3,700 when an enforcement officer visited her home. Mrs T was unaware of the small claim and the subsequent court proceedings. She disagreed that she owed any money. She said that she paid the money under pressure because she felt intimidated, but then took steps to get it back.

The *Insolvency Act 1986* requires funds collected by enforcement officers to be held for 14 days before they are released to creditors.

Mrs T immediately contacted two courts concerned in the case several times but court staff gave her confusing and conflicting advice that delayed the application process. After she applied to one of the courts, Mrs T was granted a halt to the proceedings, referred to as a 'stay of execution'. Unfortunately, HMCTS did not identify that this was urgent and did not tell the enforcement officers, who sent the money to the company after the statutory 14-day period.

Shortly after, a judge at a third court that was closer to Mrs T's home processed her application to set aside the judgment. Mrs T contacted the enforcement officers but was told the money had been sent to the company. Efforts to recover the money from the company were unsuccessful.

Mrs T complained to HMCTS and the enforcement officers, but both organisations denied responsibility for sending the money to the company.

What we found

We partly upheld this complaint. We did not uphold the complaint about the enforcement officers. As they did not receive the 'stay of execution' from HMCTS, they acted in line with their processes when they released the money.

HMCTS should have identified that the 'stay of execution' was urgent, and should have made sure that the enforcement officers were aware of it. Its failure to do this meant the money was released, when it should have been retained and returned directly to Mrs T.

The courts gave conflicting advice and HMCTS's complaint handling was inadequate, adding to Mrs T's frustration.

Putting it right

We asked HMCTS to return Mrs T to the financial position that she would have been in, had the errors not occurred. We also recommended a substantial payment to recognise the distress and inconvenience caused by the fact that it took four years to resolve this complaint. The stress had a significant impact on Mrs T's family relationships. We also asked HMCTS to apologise and to make systemic changes to clarify the process.

Following our investigation, HMCTS apologised to Mrs T for the shortcomings we found. It paid Mrs T the money she had paid the enforcement officers, and interest on this sum. It also refunded fees she paid when she tried to get the money back from the company plus interest.

In addition, it paid her £1,000 to recognise the distress and inconvenience it had caused.

HMCTS agreed to carry out systemic improvements to make sure that courts are clear on enforcement officers' processes and to take steps to prevent this situation happening again.

Organisation(s) we investigated

HM Courts and Tribunals Service (HMCTS)

High Court enforcement officers

Summary 637/January 2015

Legal Aid Agency mishandled complaint

Mr P received legal aid for a court case. This was stopped part way through the case. The Legal Aid Agency held onto the final settlement until it could calculate how much Mr P owed it. Mr P felt this was wrong because he did not get legal aid for the entire case.

What happened

Mr P received legal aid for a court case. In 2010, legal aid was removed because his solicitors could no longer use it for the case because the value of the claim did not justify the cost of continuing. However, Mr P continued with the case and represented himself. There was a £20,000 settlement at the end of the case, and both parties paid their own legal costs.

The Legal Aid Agency held onto the settlement until it had decided how much Mr P owed it under the statutory charge. The Legal Aid Agency levies the statutory charge in cases where a person who has used legal aid for their court case gets or keeps money or property at the end of the case. It is how legal aid is paid for.

Mr P wrote to the Legal Aid Agency about the release of the settlement, but he did not get a response. A family member spoke to the Legal Aid Agency several times, and said a manager was rude during one of the calls. Mr P made a formal complaint in winter 2011. In the complaint, he mentioned the manager his relative had spoken to. He also asked for more information about the settlement.

The manager Mr P had complained about replied to Mr P's complaint. He answered Mr P's query about the settlement but did not address Mr P's concerns about his own management of the case. He explained that Mr P's legal aid had amounted to around £30,000. The manager said the Legal Aid Agency would offset this against the money Mr P had recovered, using the statutory charge.

In summer 2013, the Legal Aid Agency issued its final decision. It apologised for the delay in responding to his complaints and explained that Mr T had to repay his legal aid costs because his final bill was higher than the settlement amount and therefore no refund was due to him.

Mr P argued that his case did not conclude under legal aid, although he had had legal aid in the initial stages, and therefore the statutory charge should not be applied to the full settlement. The Legal Aid Agency's final response said the statutory charge applied and the whole settlement would be offset against Mr P's legal costs.

What we found

We partly upheld this complaint. The Legal Aid Agency correctly applied the statutory charge to the settlement Mr P received. This is because he recovered the money using information and advice that he had been given under legal aid funding, so he was liable to repay the legal costs. The Legal Aid Agency was reasonable to say that as Mr P's final legal bill was higher than the settlement amount, the settlement was offset against his outstanding legal aid costs. We did not uphold this part of Mr P's complaint.

The Legal Aid Agency failed to be open and accountable when it allowed an individual manager to respond to a complaint about himself, and it also missed several opportunities to put things right. Its handling of Mr P's complaint was poor because it failed on numerous occasions to let him know that

he would not get any money. That was not customer-focused. We upheld this part of Mr P's complaint.

Putting it right

The Legal Aid Agency apologised for its failure to acknowledge or address Mr P's concerns about how it managed his case. It paid him £200 in recognition of the distress and frustration he experienced as a result of its failure to respond to his enquiries about the release of the settlement.

In addition, we note that since 2014, the Legal Aid Agency's procedures have been explicit that individual members of staff should not deal with complaints about themselves. The Legal Aid Agency issued a reminder to staff to make sure they respond to complaints about individuals in line with the Agency's procedures.

Organisation(s) we investigated

Legal Aid Agency

Summary 638/January 2015

Asylum seeker waited 18 months for routine decision on application to settle in the UK

UK Visas and Immigration (UKVI) delayed making a decision on Mrs M's application to settle in the UK. Mrs M was an asylum seeker who had been living here for over nine years.

What happened

Mrs M sought asylum in the UK in 2001 with her family. She was given two periods of limited leave, up until 2012. In 2012, as she had been in the UK legally for over six years, she applied for indefinite leave to settle in the UK, which she was entitled to do. But no team in UKVI took responsibility for looking at her application and for over 18 months it was passed from team to team, and was eventually put into storage. UKVI finally granted her indefinite leave to remain in spring 2014.

What we found

Mrs M's application was straightforward. UKVI should have found a suitable team to deal with her application. Had it done so, there is no reason why it would not have made a decision in 2012. As a result, Mrs M experienced unnecessary delay, causing her stress and uncertainty.

Putting it right

Following our report, UK Visas and Immigration apologised to Mrs M and paid her £250 to recognise the stress and uncertainty that arose from its errors.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 639/January 2015

HMCTS failed to consider man's needs when it wrote to him about a tribunal claim

After Mr B submitted a claim at an employment tribunal, HM Courts & Tribunals Service (HMCTS) sent him two different letters on the same day. This caused confusion over how the tribunal would deal with the claim.

What happened

When he was made redundant, Mr B submitted a claim to an employment tribunal for a protective award, a financial award made to employees if a company does not inform or consult with employees in the correct timescale. The tribunal then sent him two different letters on the same day.

The tribunal's first letter told Mr B that his claim had been accepted. It suggested that it could issue a default judgment against the employer after 28 days. The second letter told Mr B that his employer had gone into administration, and his claim could not proceed without the consent of the company's administrator, or the permission of the court that granted the administration order. The second letter also said that a judge would consider Mr B's claim in six months, at which time it could be struck out if he had not actively pursued the matter.

Mr B contacted the company's administrator, but could not get its consent to his claim, so he emailed the tribunal to tell it about this. Nothing happened on his case for two years and eight months. The tribunal then wrote to Mr B to ask him if he still wanted to pursue his claim. Mr B wanted to pursue the claim, but by this time the employer had been dissolved as a company, which made it much more difficult for Mr B's claim to be heard.

Mr B complained to HMCTS about the delay in its handling of his claim, and asked HMCTS several times to explain why a default judgment had not been made against the company after 28 days. He wanted HMCTS to pay him compensation to remedy the difficulties he now faced in pursuing a claim against the employer. HMCTS agreed there had been a delay in the tribunal's handling of Mr B's case and offered him a goodwill payment of £50, but it refused to compensate him further. Mr B asked his MP to refer the complaint to us.

What we found

We partly upheld this complaint. HMCTS failed to consider the impact the letters sent to Mr B on the same day would have had. Mr B had asked why his claim had not been put before a judge after 28 days. The correct position was that his claim could not have been put before a judge because the company was in administration. Mr B would have been upset by receiving differing information and, as a person with no specialist legal knowledge, he would have been frustrated by having to clarify what the correct position was. Although there was a delay in the tribunal's handling of the claim, HMCTS's failings had not left Mr B in a materially worse off position. We could not say that it was likely his claim would have been heard because the company had already been put into administration. HMCTS could have better answered Mr B's questions when it responded to his complaint.

Putting it right

HMCTS apologised to Mr B for the frustration he was caused by receiving information in a confusing manner, and also by not receiving answers to all of his questions in the response to his complaint.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 640/January 2015

Children and Family Court Advisory and Support Service wrongly used information then failed to spot this when challenged

The Children and Family Court Advisory and Support Service (Cafcass) added incorrect information about an alleged assault to a report that it was preparing for the family courts. The information was wrongly taken from a handwritten note of data held on the Police National Computer.

What happened

Mr G was in a dispute with his ex-partner about contact with his children. A county court heard the case and asked Cafcass for more information to help with its decision. Cafcass produced a report that contained information from the Police National Computer about an alleged assault. Cafcass's report correctly showed that the police had taken no further action on the allegation. However, the report gave incorrect information about the type of assault that had been committed.

Mr G's solicitor wrote to Cafcass three times asking it to clarify where the information had come from. The solicitor also explained that evidence obtained from the police did not agree with the statement in the report. Cafcass failed to respond to the solicitor, and it was five months before Cafcass realised the handwritten entry had been copied incorrectly. Cafcass then took steps to clarify the information in the report with the court.

Mr G complained to Cafcass that he had incurred unnecessary legal costs because of its failing. Cafcass initially offered to pay Mr G the £10 he had paid to obtain evidence from the police. Mr G was unhappy with this outcome and asked his MP to refer the complaint to us.

When we proposed to investigate the complaint, Cafcass noted that Mr G had paid legal costs for his solicitor to write letters of complaint about the inaccurate information. Cafcass offered to reimburse these costs and we put this offer to Mr G. He declined the offer and said he had been caused further costs as a result of Cafcass's failing, so we decided to go ahead with an investigation.

What we found

We did not uphold this complaint. Cafcass had wrongly copied the handwritten note, but we concluded that the impact of this failing was not as great as Mr G claimed. We agreed with Cafcass that it should reimburse the costs Mr G had paid for his solicitor to complain about the entry, but we did not find that Cafcass's error was linked to any other legal costs that Mr G had paid. We did not uphold the complaint because Cafcass had already offered to do enough to put matters right for Mr G. Cafcass also confirmed that it no longer relied on handwritten transcripts from the Police National Computer, so we were satisfied a similar incident would not happen again.

Putting it right

Cafcass had already offered to do enough to put matters right for Mr G, so we did not make any further recommendations.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 641/January 2015

Driver and Vehicle Standards Agency failed to properly investigate complaint of racism and failed to put things right

Mr P complained that Driver and Vehicle Standards Agency (DVSA) test centre staff treated him disrespectfully and wrongly accused him of attempting to impersonate other candidates and take the driving test on their behalf. Mr P said the staff discriminated against him because of his race.

What happened

Mr P was turned away from a driving test theory centre because staff said he had already taken the driving theory test and had impersonated other candidates. Mr P denied this and complained staff were racist towards him. Although he had been told that he could reapply to take the test, Mr P was turned away a second time.

Mr P complained to DVSA but was not happy with the outcome. The Independent Complaints Assessor (ICA), the organisation that investigates complaints about the Department for Transport and its agencies, investigated and partly upheld Mr P's complaint. However, Mr P was not satisfied with the amount of financial compensation the ICA recommended.

What we found

We partly upheld this complaint. Although test centre staff were mistaken in their belief that Mr P had attended the test centre previously, they acted in line with DVSA's internal guidance when they first turned him away. However, DVSA failed to properly investigate the staff's suspicions at the right time, which meant the opportunity to examine whether there was any validity in those suspicions was lost. DVSA also failed to act upon the evidence Mr P gave it to prove he could not have been at the test centre on the previous date.

There was an apparent disconnection between DVSA's fraud investigation and its complaints processes. DVSA dismissed Mr P's allegations of racism but there is no evidence it took any action to investigate his complaint about this. DVSA found no evidence he had impersonated anyone, but it also did not tell Mr P this. It also did not tell him that it had finished its investigation. DVSA says it takes allegations of racism against its staff very seriously, but it failed to do so on this occasion.

It took over seven months for DVSA to answer Mr P's complaints that his treatment amounted to racism. We agreed with the ICA when it said this was '*completely unacceptable*'.

DVSA's failings caused Mr P humiliation and distress. The poor complaint handling caused him inconvenience and effort because he had to chase his complaint over a period of nine months. He became genuinely reluctant to take his test again because his efforts to prove he was not an impersonator were ignored, and this led him to expect the same treatment on a third occasion.

DVSA's failure to investigate Mr P's concerns properly, and its failure to tell him that the fraud investigation was dropped, reinforced his belief that staff discriminated against him. Mr P's representative gave us a compelling account of

the impact of these failings on Mr P and why he thought the motivation for his treatment was racism. As a refugee in this country, he felt badly treated and let down by the state.

The ICA had made some recommendations to put things right for Mr P but we thought DVSA should do more.

Putting it right

DVSA paid an additional £250 to Mr P and reviewed the procedures for investigating complaints of racism in theory test centres.

Organisation(s) we investigated

Driver and Vehicle Standards Agency (DVSA)

Summary 642/January 2015

Small but repeated errors amounted to unacceptable level of service

HM Courts & Tribunals Service (HMCTS) failed to give Mr C the level of service he was entitled to expect. It was not customer-focused, and Mr C lost confidence in it.

What happened

Mr C was representing a relative in an appeal hearing that involved the Department for Work and Pensions (DWP). Unfortunately, before the hearing took place, HMCTS lost the appeal paperwork and asked Mr C and DWP to provide copies. Although Mr C sent copies of the paperwork, DWP could not do so as it believed it had destroyed its copies of the papers. HMCTS subsequently apologised for losing the paperwork (we did not investigate this complaint).

HMCTS received copies of the appeal papers shortly before the hearing because DWP had found them. However, HMCTS did not realise what the papers were and rather than linking them to the existing appeal, it created a new appeal. Although Mr C pointed this out, HMCTS did nothing until a judge noticed the mistake three months later.

The appeal hearing went ahead without DWP's paperwork, and was dismissed. Mr C was unhappy about this and raised concerns with HMCTS about how the tribunal panel had been selected. HMCTS referred him to the Judicial Appointments Commission, which is responsible for panel appointments.

During a telephone conversation with HMCTS, Mr C asked for the name of HMCTS's chief executive but it refused to give him this information, and referred him to its website. Eventually the HMCTS officer terminated the call.

Mr C wrote to the chief executive to complain about the panel make up and about the telephone conversation. HMCTS responded but took slightly longer to do so than its published response times. Although it again explained about the panel, it did not deal with Mr C's concerns about his telephone conversation.

Mr C had several more telephone conversations with HMCTS and also wrote to it. He said he was unhappy about the late response to his letter to the chief executive. He also raised some additional concerns about the way HMCTS had treated him. He asked HMCTS to compensate him for the time and money he had spent chasing the matter. HMCTS refused Mr C's request and said, in its internal consideration of the request, that Mr C had been '*unrealistic*' in expecting how soon HMCTS could respond to his letters.

Mr C continued to correspond with HMCTS, both by telephone and by letter. During these exchanges, HMCTS made a further error when it wrote to Mr C but did not include the author's name in the letter.

Eventually Mr C wrote to HMCTS and asked it again to compensate him for his time. He also asked it to respond to his complaints, including his concerns about the duplicate appeal. HMCTS again refused Mr C's request for compensation, saying that it had not been necessary for him to call as often as he had. However, it did not respond to his concerns about the duplicate appeal until we eventually pointed this out as part of our investigation.

What we found

HMCTS responded correctly to Mr C's concerns about the appeal panel. However, it did not give him the level of service he could have expected, particularly when it came to other aspects of his complaint.

HMCTS should have given Mr C the name of its chief executive and it had not been customer focused for it to simply refer him to its website. HMCTS should have investigated and responded to his complaint about this. We did not know whether HMCTS had good reason to terminate Mr C's telephone call, but it should have looked into this, particularly as its records clearly identified the officer responsible.

HMCTS should not have set up a duplicate appeal for Mr C, and it should have corrected this error as soon as he brought it to its attention. HMCTS should also have responded to Mr C's concerns about this before we intervened in the matter.

There was no fault in HMCTS's failure to respond to Mr C's letter to the chief executive within its published timescales. The time limits were an aim and there would be times when the aim could not be met, through no fault of HMCTS. However, we did not accept that Mr C's expectations were '*unrealistic*'. We said they were based on HMCTS's published information and, if HMCTS felt the published time-scales were '*unrealistic*', it should change them.

HMCTS made several errors in its dealings with Mr C. Most of these, alone, were not serious enough to be maladministration. However, when looked at together, they added up to an unacceptable level of service, particularly as they came so shortly after a more serious error by HMCTS (the loss of Mr C's appeal paperwork).

In the circumstances, we could understand why Mr C had begun to lose confidence in HMCTS and this explained why he had felt the need to contact it more often than might usually have been the case.

Putting it right

HMCTS apologised to Mr C for its unacceptable level of service and paid him £500 to recognise the inconvenience and frustration this had caused him.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 643/January 2015

Mother concerned about court adviser's referral

A family court adviser became concerned about Ms A's children and made a referral to the local authority. Ms A was very unhappy about this and the work of the family court adviser in general, and complained to the Children and Family Court Advisory and Support Service (Cafcass).

What happened

Ms A's children's paternal grandparents made an application for contact with her children. A family court adviser was asked to report to the court on the application. During her enquiries, the family court adviser became concerned about the emotional wellbeing of the children. She made a referral to the local authority and recommended that the court should order a report from the local authority on the family situation as a whole. The court ordered this and the local authority reported no concerns.

Ms A considered that the favourable report from the local authority proved that the family court adviser had not done her job properly, and she had been wrong to have referred the case as she did. Ms A was also concerned about the enquiries the family court adviser made, and felt that there were a number of factual errors in the report.

Cafcass upheld part of Ms A's complaint but did not agree that the family court adviser was at fault in referring the case to the local authority. It said that the family court adviser had used her professional judgment.

The paternal grandparents dropped the application and the local authority was no longer involved. However, Ms A felt that she and her family had been put through unnecessary distress and that the family court adviser's report was still on record. She wanted Cafcass to accept that there had been errors and to apologise. She also wanted financial redress.

What we found

We did not uphold this complaint. There was no evidence to demonstrate a failing by the family court adviser as Ms A described. There were times when the family court adviser had not provided the level of service that Ms A and her family had a right to expect, but we did not feel that there was evidence to question her professional judgment in involving the local authority in Ms A's case.

Putting it right

Cafcass had recognised the areas where its service had fallen short, and had remedied those accordingly. While we had sympathy with the distress caused to Ms A and her family by the proceedings, we were satisfied that this had not been caused by an administrative error by Cafcass.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 644/January 2015

Organisation made complaint handling error

Ms B complained about the Children and Family Court Advisory and Support Service's (Cafcass) decision not to consider her complaint about allegations made about her because the complaint was outside the six-month permitted time limit.

What happened

Ms B complained to Cafcass about information, including allegations of violence by her, that had been included in a letter to the court. Cafcass refused to consider her complaint as it said it was made after the six-month time limit had passed.

What we found

We partly upheld this complaint. Cafcass had decided not to investigate Ms B's complaint because she was not a party to the complaint, rather than because the complaint fell outside the period for complaining. Cafcass made a mistake by giving Ms B the wrong reason for not investigating her complaint.

It was reasonable for Cafcass to have included information about Ms B in the letter. These were allegations, rather than fact, and the purpose of the letter was to tell the court about any safety issues.

Putting it right

Cafcass apologised to Ms B for not explaining properly the reasons why it did not investigate her complaint. It reassured Ms B that it had not put her name on any register as a result of the allegations made in the letter.

Organisation(s) we investigated

Children and Family Court Advisory and Support Service (Cafcass)

Summary 645/January 2015

Independent Case Examiner appropriately investigated Child Support Agency

Mr P complained that the Child Support Agency had caused arrears of £11,000 child maintenance to accrue. He felt he should not have to pay these arrears.

What happened

The Child Support Agency failed to take any action to review Mr P's case between summer 2009 and summer 2013, although it was in touch with the parent who had care of the children on a number of occasions, and with Mr P himself. Because of this, maintenance arrears of over £11,000 accrued. Mr P complained to the Independent Case Examiner (ICE), the organisation that investigates complaints about the Child Support Agency.

ICE found that the arrears were correctly owed to the parent who cared for the child, and the Child Support Agency had a duty to collect them. However, the Child Support Agency's failure to contact Mr P had led to the arrears mounting up. ICE noted that the Child Support Agency was supposed to collect the arrears within 24 months, but it had extended this period to 81 months in this case. ICE awarded Mr P a consolatory payment of £250 in addition to the £75 awarded by the Child Support Agency.

What we found

We did not uphold this complaint. ICE had appropriately investigated the facts, identified the Child Support Agency's maladministration and considered the relevant injustice to Mr P.

As the Child Support Agency had failed to give Mr P an opportunity to voluntarily pay his maintenance, ICE recommended that it pay Mr P further compensation. The compensation amount ICE recommended was within the range of reasonable decisions.

Organisation(s) we investigated

Independent Case Examiner (ICE)

Summary 646/January 2015

Delay in returning passport meant missed holiday

Mr B complained that UK Visas and Immigration (UKVI) returned his passport far beyond its service standard. As a result, he had to cancel a holiday, which caused him a financial loss, inconvenience and distress.

What happened

Mr B provided his passport as evidence that he was a European Economic Area national to help his ex-wife apply for permanent residence in the UK. His ex-wife submitted her application to UKVI with his passport in early summer 2013.

Mr B intended to go on holiday to Italy with his father at the end of summer 2013. This was very important to him because his father lived in Australia and was unlikely to travel to Europe again. Mr B needed the passport that his ex-wife had sent to UKVI. UKVI's website said that it aimed to return requested documents within 10 working days. Later in the summer of 2013, Mr B's ex-wife asked UKVI to send Mr B's passport back to him. After 20 working days, she asked again.

In late summer 2013, as he had not received his passport from UKVI, Mr B cancelled his holiday. He was able to recover the deposits for his accommodation and car hire, but he lost £218.96 on his flights. Mr B said he received his passport shortly after.

Mr B complained to UKVI. He said that he wanted compensation for the cancelled plane tickets and for the inconvenience and stress caused to him and his family. UKVI refused to compensate Mr B because its website advised people not to make non-urgent travel arrangements when not in possession of a passport.

What we found

UKVI took no action to return Mr B's passport after receiving the first request from his ex-wife. UKVI was unable to explain why. It took 14 days longer than it should have done to process Mr B's ex-wife's second request to return the passport because of backlogs. As a result, Mr B missed his holiday.

UKVI's complaint handling was poor. Rather than investigating fully what had happened to Mr B's ex-wife's requests for the return of his passport, it focused on compensation. If UKVI had concentrated on the issues that caused the delay, it would have realised that it had missed its service standard twice by a considerable margin.

Putting it right

UKVI apologised to Mr B and paid him £218.96 for the lost flights and £300 to reflect the loss of his planned holiday, as well as the frustrating effects of its poor complaint handling.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 647/January 2015

Border Force unreasonably stopped and detained a woman twice

Mrs C complained that Border Force incorrectly stopped her entering the UK in 2012, saying that she did not have genuine visa, and also in 2013, because staff suspected that her passport was a fake. She also complained that the officers had been rude and intimidating.

What happened

Mrs C, a Sri Lankan national, was granted leave to remain in the UK in spring 2012. In winter 2012 she went on holiday abroad with her British husband. When she returned to the UK, Border Force detained her for further examination because staff suspected that the visa in her passport was not genuine. This was because information on Border Force's computer system showed that Mrs C did not have leave to enter the UK. Mrs C and her husband were asked to wait with no explanation for detaining them. After about an hour, Border Force allowed Mrs C to enter the UK. It said that its computer system had not been up-to-date.

In winter 2013 Border Force stopped Mrs C at an airport to make further enquiries about her passport. Mrs C was then allowed to enter the UK without any proper explanation.

In response to Mrs C's complaint about the two incidents, Border Force said that it could not look into the events in 2012 because of the time that had elapsed since then. When discussing the events of 2013, it said that it had encountered a growing number of fake passports and it had to make sure that people entered the UK with genuine documents. In Mrs C's case, the examination of her passport had been a routine procedure. In response to her complaint about the officers' rude and intimidating behaviour, Border Force said that it expected its officers to behave in a professional manner and apologised for any upset caused.

What we found

We partly upheld this complaint. Regarding the events in 2012, Border Force officers acted in accordance with its guidance but its computer records had not been correctly updated to show that Mrs C had been granted leave to remain in the UK in spring. This amounted to maladministration.

Regarding the events in 2013, we concluded that Border Force officers had acted in accordance with its guidance and we did not find that it had acted incorrectly.

Border Force's responses to Mrs C's complaint could have been more helpful, however, we did not consider that the shortcomings amounted to maladministration.

Putting it right

Border Force apologised to Mrs C for its errors in 2012. It also paid her £150 in recognition of the worry and inconvenience caused.

Organisation(s) we investigated

Border Force

Complaints about the NHS in England

Summary 648/December 2014

Lady with abdominal pain caused by cancer received poor care

Mrs A considered that her GP Practice did not investigate her symptoms properly. She also said that a hospital did not diagnose her with colon cancer during two A&E visits.

What happened

Mrs A went to the hospital's A&E department twice with abdominal pain. On both occasions, the hospital did not admit her, did not perform a CT scan (CT scans take images of the inside of the body), did not diagnose her colon cancer, and discharged her.

Soon after, Mrs A went to her GP Practice. The GP she saw did not take her pulse and blood pressure, and did not listen to her bowel. Mrs A went to hospital the next day and was diagnosed with colon cancer. The hospital promptly and effectively treated this.

Mrs A complained to the Primary Care Trust (PCT) about the care she received from the hospital and her GP Practice. In response, the PCT said that the care Mrs A had received was appropriate.

What we found

We partly upheld this complaint. The hospital's decision to discharge Mrs A after her first visit was appropriate. However, on her second visit to A&E, the hospital should have carried out a CT scan of Mrs A's abdomen and diagnosed her with colon cancer. If the hospital had done these things, Mrs A would have been spared a lot of pain.

The GP who saw Mrs A after her A&E visits should have taken her pulse and blood pressure and listened to her bowel. However, we cannot now say whether this would have led the GP to refer her to hospital.

The PCT's conclusion, that Mrs A had received appropriate care from her GP Practice and the hospital, was unreasonable.

Putting it right

The hospital and the GP Practice acknowledged the errors in their care and apologised for the effect these had on Mrs A.

The hospital and the GP Practice both agreed to take action to make sure that they learn from these errors.

NHS England Local Area Team, which took over the responsibilities of the PCT, acknowledged errors in the PCT's complaint handling and apologised for the effect this had on Mrs A.

In addition, the hospital paid Mrs A £700 in recognition of the unnecessary pain she suffered as a result of its errors.

Organisation(s) we investigated

A GP practice

Ipswich Hospital NHS Trust

NHS England Local Area Team, previously the Primary Care Trust (PCT)

Location

Suffolk

Region

East

Summary 649/December 2014

GP Practice did not perform relevant tests to exclude a possible Achilles tendon rupture

Mrs S complained that two doctors did not notice her Achilles tendon rupture when she went to the Practice with an ankle injury.

What happened

Mrs S fell and injured her ankle. She went to two appointments at her GP Practice and was diagnosed with a '*ligamentous injury*'. She was referred for physiotherapy and the physiotherapist suspected a tendon rupture. Mrs S then had tests that confirmed that her Achilles tendon had ruptured. Mrs S now needs surgery to repair the tendon.

Mrs S complained to the Practice. The Practice's review of the complaint did not consider if staff should have carried out tests to rule out a rupture.

What we found

We partly upheld this complaint. Doctors at the Practice should have excluded a possible Achilles tendon rupture before they diagnosed a '*ligamentous injury*'.

Mrs S might still have needed surgery if her rupture had been diagnosed earlier, but the delay in the diagnosis caused her distress, pain and inconvenience. She will never know if she would have needed surgery if doctors had diagnosed her rupture earlier.

Putting it right

The Practice acknowledged and apologised for its failings and paid compensation of £750. It also created an action plan to address the issues identified and arranged training on assessing ankle injuries.

Organisation(s) we investigated

A GP practice

Location

Merseyside

Region

North West

Summary 650/December 2014

Man's death from blood clots could have been avoided

Mrs D complained that the Trust discharged her husband, Mr D, without arranging adequate home support, and then the GP Practice failed to act on her husband's symptoms. She said these errors led to her husband's death.

What happened

Mr D was in his seventies. He fell and injured his hip and was taken to hospital, where doctors diagnosed that he had fractured his greater trochanter (a 'knuckle' of bone that sticks out from the top of the thigh bone).

Mr D did not need an operation and Trust staff discharged him after two mobility assessments. Doctors advised Mr D to try to move around at home.

Once at home, Mr D's condition rapidly deteriorated. His leg swelled and he was unable to move from his chair, and he later developed chest symptoms. Mrs D was sufficiently worried to call GPs to visit him on three occasions over several weeks. Three GPs came to see him but none properly identified his risk of developing blood clots. Mr D developed a blood clot in his lungs and died hours after the third GP's visit.

What we found

We partly upheld this complaint. There were some shortcomings in the Trust's discharge planning process. But the shortcomings were not serious enough to amount to service failure. Crucially, the Trust's staff would not have been able to predict Mr D's rapid deterioration at home, based on the assessments they had made while he was in hospital.

At the second and third GP visits, given Mr D's risk factors and clinical symptoms, doctors should have thoroughly considered the possibility of blood clots. They excluded this too readily, or did not properly consider it in line with established good practice. The GPs did not take adequate steps to prescribe drugs that could have helped prevent blood clots developing. Mr D's death could have been avoided had GPs taken appropriate action, particularly at the second visit.

Putting it right

The GP Practice wrote to Mrs D to acknowledge and apologise for the service failure we identified. It also paid £15,000 compensation and prepared an action plan to demonstrate learning from the complaint.

Organisation(s) we investigated

A GP practice

Royal Berkshire NHS Foundation Trust

Location

Reading

Region

South East

Summary 651/December 2014

Trusts took appropriate action to treat man's nasal problems

Mr P complained that two Trusts failed to correctly diagnose and treat his nasal condition over a number of years.

What happened

Mr P had been referred to the first Trust on a number of occasions over many years because of nasal symptoms. It referred him to the second Trust for further investigation.

Clinicians tried a number of treatments and procedures over the years but eventually concluded there was nothing more they could do to help him.

What we found

We partly upheld this complaint. Both Trusts took appropriate steps to diagnose and treat the cause of Mr P's problems. There were no failings in relation to the first Trust.

The second Trust, in a clinic letter it wrote, incorrectly referred to a family member who does not exist. This caused Mr P outrage.

Putting it right

The second Trust apologised for its error and for the outrage this caused Mr P.

Organisation(s) we investigated

Western Sussex Hospitals NHS Foundation Trust

Brighton and Sussex University Hospitals NHS Trust

Location

West Sussex

Region

South East

Summary 652/December 2014

NHS England did not explain why continuing healthcare funding was withdrawn

Mrs H's mother's continuing healthcare funding was suddenly withdrawn after five years, although her clinical condition seemed to get worse.

What happened

Mrs H complained that despite her mother having had continuing healthcare funding since 2007, there was no rational explanation for why that funding was suddenly withdrawn in 2012. This was despite an apparent deterioration in Mrs H's mother's clinical condition.

Mrs H appealed the original decision but it was upheld at the final review, so Mrs H complained to us.

What we found

We partly upheld this complaint. Mrs H's mother did not qualify for continuing healthcare funding at the time funding was withdrawn.

This was because Mrs H's needs were assessed as being purely for social care and assistance with the tasks of daily living. Her health needs had decreased since she was last assessed, and so she was ineligible for funding.

Mrs H did not understand the decision to withdraw the funding because NHS England had not explained to her how her mother's needs were different from those in 2007.

NHS England had not provided evidence that it followed the national guidelines when it considered the withdrawal of continuing healthcare funding.

Putting it right

NHS England provided a written explanation of the actions it had taken to address the apparent oversight we identified.

Organisation(s) we investigated

North of England Commissioning Region

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 653/December 2014

Man failed by poor district nursing care

Mr P complained that his father's district nursing care and treatment were negligent, which meant he had to go to hospital four times with foot infections.

What happened

In the first half of 2012, Mr P's father had a number of toes amputated because of his poor circulation. He was discharged from hospital under the care of the Trust's district nursing team. Between autumn 2012 and early 2013, a district nurse visited Mr P's father at his home on eleven occasions. During this period, he went into hospital four times with repeated foot infections.

Mr P complained that a senior district nurse failed to properly investigate his concerns, which meant he had to make a second formal complaint to the Trust.

What we found

The district nursing care provided to Mr P's father was poor and did not follow the National Institute for Health and Care Excellence guidelines or Nursing and Midwifery Council (NMC) standards. We also found failings in record keeping, which was not in accordance with NMC standards.

We could not link these failings to Mr P's father's repeated admissions to hospital with recurring foot infections. This is because he was at high risk of wound infection as he had just had surgery, was elderly, and was receiving medical treatment that weakened his immune system. However, the failings caused Mr P and his father uncertainty, worry and distress.

The actions to initially investigate Mr P's complaint were inappropriate and ill-considered. The senior district nurse did not update Mr P or tell him about the result of her investigation. This meant that Mr P had to make a formal complaint to the Trust many months later, repeating the same facts.

Putting it right

The Trust wrote to Mr P apologising for the poor district nursing care and poor complaint handling, and paid him £1,000 compensation. The Trust also prepared an action plan describing what it would do to make sure that it had learnt lessons from the failings we identified.

Organisation(s) we investigated

The Lewisham Healthcare NHS Trust

Location

Greater London

Region

London

Summary 654/December 2014

Patient unreasonably discharged twice in one day after day-case surgery

Mr C had day surgery at Surgicentre, a private company that provided services to the NHS. He was unreasonably discharged twice and both times he had to be re-admitted.

What happened

Mr C was admitted for surgery as a day case to the Surgicentre, which at the time was run by Clinicenta Limited. Staff discharged him after the procedure, but when he arrived home, he noticed that he was still bleeding heavily from the operation wound. He had to return to the Surgicentre, where staff took action to stop the bleeding. Later, he was discharged again when his blood pressure was low, but on the way out of the building, he collapsed. He had to be admitted overnight to hospital.

What we found

We partly upheld this case. Although the bleed was an unfortunate complication of this procedure, both discharges were unreasonable. On the first occasion, nursing staff did not check the dressing before telling Mr C he could leave. The second time, Mr C's blood pressure was low and he should have been kept in for further observations before being discharged. The surgeon had not kept adequate records, but this did not appear to contribute to Mr C's distress.

Putting it right

Clinicenta no longer provides NHS services, so we made no recommendations to improve its service. We did, however, ask it to pay Mr C £500 to recognise the avoidable distress that he had experienced. Clinicenta agreed to do so.

The surgeon agreed to consider and reflect on our findings regarding his record keeping.

Organisation(s) we investigated

Clinicenta Limited

Location

Hertfordshire

Region

East

Summary 655/December 2014

Young woman with disabilities admitted to hospital with breathing difficulties and given wrong oxygen levels

Ms A complained that her daughter, Miss B, was given too much oxygen in hospital and this was not recognised soon enough, which led to delay in her treatment.

What happened

In summer 2010 Miss B was admitted to hospital with breathlessness. She was placed on a paediatric ward despite being a young adult because she was familiar with it and staff knew her. Staff gave her oxygen but a specialist did not see her for seven days. When she was seen, a cardiologist suggested giving her oxygen saturation levels for a patient of Miss B's age, but staff could not manage these levels on the paediatric ward, because of her weight, age and their being used to managing children. Staff didn't realise how important the specified oxygen levels were, and Miss B continued to be over-oxygenated (at a level usually used for children), which worsened her condition.

Also, in investigating her symptoms, the respiratory consultant said that Miss B's obesity and scoliosis (abnormal curvature of the spine) would 'not usually' cause low oxygen levels. Because her oxygen levels were not recognised, the consultant did not take appropriate action, which would have been to transfer her to an adult unit for other, long-term, treatment.

Some 14 days after Miss B had been admitted, a physiotherapist noticed her sleep apnoea condition (sleep apnoea causes breathing interruption when a person is sleeping). Staff had missed this when they had previously investigated Miss B's condition, and it was one of the reasons for her low oxygen levels. This led to a further delay in suitable treatment. Five days later, Miss B was moved to a more suitable adult ward at another hospital where staff were more able to manage her low oxygen levels.

Miss B died 11 days later from respiratory failure and infection.

What we found

Miss B was inappropriately placed on a paediatric ward where staff were unfamiliar with the adult guidelines for her care.

There was fault in the seven-day delay in getting a cardiology and respiratory opinion and diagnosis.

There was fault in the respiratory consultant's opinion that Miss B's existing conditions would not be affected by the higher levels of oxygen she received on the paediatric ward.

There was also fault in overlooking Miss B's sleep apnoea for 14 days, and the two-week delay in proper treatment.

Miss B was left in prolonged unnecessary discomfort and suffering. Ms A was also left in great distress watching her daughter's decline without an explanation of her diagnosis and treatment.

Putting it right

The Trust apologised to Ms A for the faults we identified and paid her £1,000 in recognition of her distress. It has completed an action plan to address the faults found.

Organisation(s) we investigated

Mid Staffordshire NHS Foundation Trust

Location

Staffordshire

Region

West Midlands

Summary 656/December 2014

Patient experienced problems with a test to view her airways

Mrs F complained about distress she felt while undergoing a bronchoscopy procedure and the effect this has had on her afterwards.

What happened

Mrs F said that when she had a bronchoscopy procedure (a fibre optic device passed through the mouth or nose to view the large airways), attempts to anaesthetise her were unsuccessful. The procedure caused her considerable distress at the time and for months afterwards. She also complained about other parts of the procedure.

What we found

We partly upheld this complaint. The record keeping for this procedure was thorough and showed that on the balance of probability, Mrs F had not been effectively anaesthetised during the procedure.

Two other issues she raised were not recorded. On the balance of probability we decided that the Trust had provided a reasonable response to these issues.

Putting it right

The Trust offered an unreserved apology to Mrs F for the failure to anaesthetise her effectively and the effect that this had upon her.

Organisation(s) we investigated

East Lancashire Hospitals NHS Trust

Location

Blackburn with Darwen

Region

North West

Summary 657/December 2014

Poor record keeping led to partly unresolved complaint

Mrs A's dental problem was not diagnosed in A&E but later by an emergency dentist. But poor record keeping in A&E failed to show staff had made an error.

What happened

Mrs A had severe toothache and went to an emergency dentist, who gave her antibiotics. This did not relieve the pain and her face and neck began to swell, so she went to A&E (urgent care service, provided by Partnership of East London Co-operatives Limited). A nurse practitioner saw Mrs A and concluded that she had not been taking the antibiotics long enough for them to be effective. She gave Mrs A stronger analgesia and discharged her.

Mrs A's symptoms did not improve and her face and neck continued to swell, which affected her speech and eating. She went to another emergency dentist, who diagnosed Ludwig's Angina which is a type of skin infection that occurs under the tongue and is a very rare and serious condition. The dentist referred Mrs A directly to hospital, where she was admitted so staff could drain the infection. She had antibiotics at the hospital and surgery to remove a tooth.

Mrs A complained that the nurse practitioner in A&E did not take all her symptoms into account, and did not assess her properly. She says the nurse practitioner, along with a doctor she consulted, failed to recognise that her symptoms indicated she was suffering from Ludwig's Angina. She felt it was inappropriate for the nurse practitioner to discharge her home.

What we found

We partly upheld this complaint. There were some differences between Mrs A's and the nurse practitioner's accounts of what happened during the A&E consultation, but we could not resolve these differences because there were no witnesses.

The consultation notes taken by the nurse practitioner were inadequate and did not fully capture the symptoms she observed, the checks and examinations she carried out, or the advice she gave Mrs A.

We therefore could not say if any of Mrs A's symptoms were missed, or that there were failings in the care given by the nurse practitioner or in her decision to discharge Mrs A.

This was a failing in record keeping. However, we could not say this contributed to the distress Mrs A experienced at the time. For this reason we partly upheld the complaint.

Putting it right

Partnership of East London Co-operatives Limited created an action plan to address, with the nurse involved, the failing in record keeping we identified.

Organisation(s) we investigated

Partnership of East London Co-operatives (PELC) Limited

Location

Greater London

Region

London

Summary 658/December 2014

Poor service around an older woman's discharge from hospital

Nursing staff should have raised Miss A's discharge with a doctor or senior member of staff when Miss A refused to be discharged from hospital.

What happened

Miss A was admitted to hospital in winter 2011 after a fall. She stayed in hospital until early spring 2012, when she was discharged to a nursing home.

Miss A initially refused to be discharged. The Trust did not tell any members of Miss A's family about its decision to discharge her until the morning of the day she was to be discharged. She was agitated when an ambulance arrived to take her to a nursing home. Eventually she calmed down and agreed to leave in the ambulance. Miss A was discharged in a dishevelled state with a cannula (tube) still in her arm.

Some of Miss A's property went missing in hospital.

What we found

We partly upheld this complaint. The hospital did not respond appropriately to Miss A's initial refusal to be discharged. The staff should have attempted to persuade her to leave, and raised the matter with a doctor or senior member of staff. Instead, a nurse inappropriately said something to the effect of: '*Miss A still has to be discharged*'.

There were some failings in the hospital's communication with Miss A's family. Staff should have told the family about the decision to discharge Miss A before she was discharged

The hospital mislaid some of Miss A's possessions.

Putting it right

The hospital acknowledged the errors in its service and agreed to take action to make sure that it learns from these errors.

Organisation(s) we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South East

Summary 659/December 2014

A dentist did not properly investigate toothache, which led to pain, inconvenience and further treatment

Mrs Q complained that a dentist made an inaccurate diagnosis of her toothache. She said that if the dentist had found tooth decay at an earlier stage, she would not have needed an extraction. Mrs Q also complained about the length of time it took for the Practice to respond to her complaint.

What happened

Mrs Q went to the dentist twice, in autumn and early the next year, with pain in one of her teeth. The dentist examined her teeth and took an X-ray but found no problems. The dentist recommended that Mrs Q use special toothpaste, and this gave her some relief from the pain.

Mrs Q returned to the dentist in early summer with severe pain. The dentist did some tests and found decay in an upper molar tooth. The dentist referred Mrs Q for root canal treatment but this could not be done as the specialist said the tooth could not be restored. Mrs Q decided to have the tooth taken out. She complained to the Practice the next month but the Practice did not respond for five months.

What we found

Mrs Q and the dentist had very different recollections of what happened during her first two appointments. The dentist did not carry out adequate tests at those appointments and these might have led to the dentist finding the tooth decay at an earlier stage.

The dentist took correct action at the third appointment. We could not say whether Mrs Q could have avoided having her tooth taken out if the problem had been found earlier. Nevertheless, she experienced pain and discomfort and could not eat and drink normally over a long period of time. She could also have had her tooth taken out earlier, avoided the pain and discomfort, and not have had so many investigations.

The Dental Practice's complaint handling was poor, which led to Mrs Q losing faith in it.

Putting it right

The Dental Practice wrote to Mrs Q acknowledging and apologising for the failings and the injustice. It paid Mrs Q £300. It agreed to prepare an action plan to explain what the Practice has done and/or intends to do to avoid a recurrence of the failings we found.

Organisation(s) we investigated

A dental practice

Location

Devon

Region

South West

Summary 660/December 2014

Trust failed to act on early signs of a heart attack in older woman

Mrs J could have been referred to cardiologists much earlier if the Trust had acted on an early abnormal ECG tests result, and signs she may have another heart attack.

What happened

Mrs J, who was in her nineties, arrived by ambulance at the Trust's A&E department in autumn 2012. She was short of breath and had pulmonary oedema (an excess of watery fluid on the lungs). She was triaged in early afternoon but died in the emergency department in the early evening of the same day.

Mr J complained that his wife spent four hours on a trolley in the A&E department without being attended to. After two hours staff started her on a drip to reduce her heartbeat and later gave her an injection into her wrist to help the pain. Minutes later, she died. Mr J said his wife should have been sent to a cardiology ward to receive care.

What we found

We partly upheld this complaint. Mrs J arrived at A&E in early afternoon with heart disease and heart failure, and the doctors were aware that she had suffered a heart attack (when the supply of blood to the heart is suddenly blocked, usually by a blood clot) in the 24 hours before she arrived.

A junior and a senior doctor both saw her, she had an ECG, and appeared to respond reasonably well to an infusion of medication. She suddenly became agitated in the early evening, most likely because of the heart attack she had before arriving at that Trust. Staff gave her some intravenous morphine but her condition deteriorated to a cardiac arrest (fast heart beat leading to an electrical malfunction of the heart) from which she died. This was almost certainly due to an extension of her earlier heart attack rather than any mismanagement by the Trust. We found nothing of concern in these aspects of Mrs J's care.

Shortly before her death however, a second ECG showed changes in her condition which prompted doctors to call cardiologists at another hospital (as the Trust did not have a cardiology department), but while they were on the phone, Mrs J died.

We found that the ECG tests taken on Mrs J's arrival at the Trust showed that she had a high indicator for a possible future heart attack. It appears that the clinicians did not act on this and could have considered referring her to cardiologists much sooner than they did.

In its response to Mr J's complaint, the Trust said there was nothing more it could have done, but this was not reasonable. The doctor, when he called the cardiologists at another hospital, was actually discussing whether Mrs J was a candidate for heart surgery when she died.

While Mr J was concerned about Mrs J's time on the trolley, we did not reach a view that this was unreasonable but instead we focused on the care she received. Mr J complained that she was left for four hours with no medical intervention, but this was not the case.

Putting it right

The Trust wrote to Mr J to acknowledge and apologise for not referring Mrs J to cardiologists much earlier that it did.

The Trust conducted an investigation to find out why Mrs J's positive indicator for a heart attack was missed and the abnormal ECG results were not reviewed, escalated or acted on. It also produced an action plan to show how it would reduce the likelihood of this happening in the future; to make sure that staff seek earlier cardiology investigation; and to show that it had learnt lessons from the failing we found.

Organisation(s) we investigated

Stockport NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 661/December 2014

Dentist did not perform adequate investigation and failed to find several cavities

Mrs T complained about the dental care and treatment her daughter received.

What happened

Ms L, who was in her twenties, went to the dentist for a regular check-up. The dentist visually examined her teeth and told her that she did not need any dental work. Ms L went back to the Practice four weeks later with toothache. She saw a different dentist who took some X-rays and found she had decay in two teeth. Ms L had three fillings at a cost of £235. Mrs T complained to the Dental Practice on her daughter's behalf.

Responding to Mrs T's complaint, the Practice said that Ms L's teeth are naturally yellow in colour and this can make it difficult to see cavities. It apologised and offered £100 as a gesture of goodwill.

What we found

The first dentist should have taken some X-rays at the first appointment to check for decay that may not have been visible to the naked eye. If the colour of Ms L's teeth made decay difficult to see, then there was even more reason to take X-rays to make sure nothing was missed.

The lack of proper examination and investigation meant that the first dentist did not find Ms L's tooth decay, and it therefore progressed. However, we could not say that Ms L would not have needed the fillings if the first dentist had taken different actions.

Putting it right

The Practice wrote to Ms L to acknowledge the failings and explain how it would prevent these from happening in the future. We saw no grounds to increase the sum of compensation already offered.

Organisation(s) we investigated

A dental practice

Location

Hertfordshire

Region

East

Summary 662/December 2014

Trust's delay in reacting to patient's deterioration caused upset but did not contribute to his death

The Trust should have told Mrs R sooner that her husband's condition was getting worse so that she could have seen him before he lost consciousness.

What happened

Mr R was admitted to hospital because he was suffering from confusion. He was diagnosed with encephalitis, an inflammation of the brain.

After a few days, Mr R became significantly more unwell, and lost consciousness. Unfortunately, he never regained consciousness, and died the following week.

Mrs R complained to the Trust about her husband's care. She said that if he had been treated differently he might have recovered. She was also upset because she was not told that her husband was becoming more unwell, and so she did not have a chance to see him before he lost consciousness.

The Trust responded to her complaint in writing and arranged a meeting to discuss her concerns. She complained to us because she did not agree with the Trust's explanations and she had not received a recording of the meeting.

What we found

We partly upheld this complaint. There was a delay in reacting to Mr R's worsening condition. However, he became so seriously ill that we did not think there was any treatment that would have helped. The Trust should have told Mrs R sooner that her husband's condition was getting worse. The Trust also took too long to give Mrs R a recording of the meeting.

Putting it right

The Trust acknowledged the delay in reacting to Mr R's deterioration, and explained what it had done to improve its services. It also apologised to Mrs R for not telling her soon enough that Mr R was getting worse. We sent Mrs R a copy of the meeting recording.

Organisation(s) we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 663/December 2014

Trust did not properly assess condition of older patient with lung cancer

Mr S was told by Trust he had a terminal illness and would not be able to stand having invasive treatment. But he got a second opinion and made a full recovery.

What happened

Mr S was in his eighties when he was diagnosed with lung cancer. The Trust did not consider him suitable for treatment but he obtained a second opinion which said he could have radiotherapy. Mr S made a full recovery.

What we found

The Trust did not follow relevant guidance for determining a patient's general well-being or activities of daily life, the National Institute for Health and Care Excellence guidelines, or established good practice. Mr S suffered considerable shock and anguish at being given a prognosis of terminal illness.

Putting it right

The Trust acknowledged the failings and apologised to Mr S. It reviewed and took necessary action regarding its planned treatment of lung cancer, and also regarding its multidisciplinary team meetings. The doctor acknowledged her failings to follow established good clinical practice and apologised to Mr S for the distress and anxiety caused.

Organisation(s) we investigated

Warrington and Halton Hospitals NHS Foundation Trust

Location

Warrington

Region

North West

Summary 664/December 2014

Dentist gave poor care

Mrs G said the dentist did not properly treat one of her teeth and a filling fell out of another one. She complained, but the Practice did not respond because the dentist had been temporary staff and had left the Practice.

What happened

Mrs G went to the Practice in summer 2012 and the dentist took X-rays.

She went back to the Practice in early 2013 complaining of a chipped tooth and a hole in her crowned tooth. The dentist told her to keep the hole clean and he put a white filling in the other tooth.

Mrs G went back in autumn 2013 and the dentist removed the crown but the tooth beneath could not be saved. Mrs G said she thought it could have been saved if the dentist had taken earlier action and said she was distressed at having a noticeable gap in her mouth. The white filling fell out just a year after it had been put in.

She complained at the end of that year, but the Practice did not give her a proper response, because it could not contact the temporary dentist to ask him about the treatment.

What we found

The dentist should have examined Mrs G's X-rays in summer 2012. Her dental records did not show that the crowned tooth had been properly examined.

We could not say the crowned tooth could have been saved, but we recognised it was a missed opportunity to treat it earlier.

The dentist should have given her a more thorough examination in early 2013 and discussed all the options for the filled tooth, giving her a choice of a white or amalgam filling (as white fillings do not last as long). We could not say it was a failing that the white filling fell out, but the dentist did not give Mrs G the choice of fillings. The dentist should have also made better notes of the appointment.

The Practice should have responded to Mrs G's complaint because it was the responsible for the locum dentist.

Putting it right

The Practice apologised to Mrs G and paid her £799 to compensate her for the replacement filling, the poor complaint handling and the loss of opportunity to treat the crowned tooth.

It also agreed to draw up an action plan to explain how it would stop this happening again.

Organisation(s) we investigated

A dental practice

Location

North Somerset

Region

South West

Summary 665/December 2014

Poor communication between hospital departments adds distress to patient who needed end of life care

Mr R complained on behalf of his late father, Mr D, about the care and treatment he received from the Trust. Mr R was specifically unhappy that his father was moved from the A&E department, and ward staff were not prepared for his arrival.

What happened

Mr D was brought to A&E in early spring 2012 following a cardiac arrest. He lost consciousness but did not die. Staff tried to revive him but this was unsuccessful and they advised Mr D's family that his death was imminent.

Mr D went onto the Liverpool Care Pathway (LCP), although the documentation for this was not signed. The LCP was used (it is no longer used) to make sure the patient was comfortable and had dignity at the end of their life, after doctors had assessed that their illness was terminal.

Clinicians prescribed Mr D sedatives and pain relieving drugs which are often used as part of palliative care. Mr D was transferred from A&E to a ward with no transfer documentation, and the ward staff were not fully aware that he was due to arrive. He died early the next morning.

What we found

We partly upheld this complaint. Although it was appropriate to move Mr D from A&E, this was poorly communicated and would have only added to what was an already difficult and stressful situation for Mr D and his family.

The lack of signed LCP documentation did not prevent Mr D from receiving the correct medication. We are satisfied that staff had already given Mr D relevant and appropriate palliative medication, despite the fact that the paperwork had not been signed.

Had the nursing staff been aware that they were to receive a patient in the last few hours of his life, they would have been able to make sure a suitable environment was ready for him, as well as giving the family a more informed and compassionate welcome.

Putting it right

The Trust acknowledged and apologised for the failings in communication and for the time taken to address the complaint. It also produced an action plan showing what it had done or planned to do to reduce the likelihood of such events happening again, and what it had learnt from the failings identified.

The Trust also paid Mr R £500 to acknowledge the distress caused by the failings we identified.

Organisation(s) we investigated

Kettering General Hospital NHS Foundation Trust

Location

Northamptonshire

Region

East Midlands

Summary 666/December 2014

Failure to diagnose lung cancer while in hospital

Mrs M complained about the care and treatment her late husband received during two admissions to the Trust. Mrs M believed that the failings in care led to her husband's death.

What happened

Mr M was in his seventies and went to the A&E department at the Trust's hospital because he had fallen out of bed and was feeling generally unwell. Doctors examined him and arranged blood tests and a chest X-ray. He was admitted and treated for pneumonia with antibiotics and fluids. Staff discharged him home after a week.

Approximately four months later, Mr M returned to A&E. He had fallen, and had pain and swelling in his knee. He was admitted, but investigations of his knee did not reveal any obvious fracture. The plan was to fit a splint, send him home and see him again in two weeks. However, before Mr M could be discharged, he developed symptoms that doctors put down to a chest infection or possibly pneumonia. They planned to treat him with antibiotics and fluids.

Mr M then had a chest X-ray, and this showed he might have lung cancer. A later scan confirmed this and further investigations showed that Mr M's cancer was advanced and had spread to his liver. Mr M stayed in hospital for approximately three weeks before being discharged so that he could go home to die, in line with his and his family's wishes. He died the day after returning home.

What we found

We partly upheld this complaint. Doctors assessed Mr M and treated him for pneumonia during his first admission to hospital, but they did not consider the alternative diagnosis of lung cancer.

Although a chest X-ray taken at the time showed a suspicious lesion, doctors did not arrange the further investigations and treatment that Mr M's condition warranted, as the General Medical Council's *Good Medical Practice* states they should have done.

This meant that doctors' decisions about Mr M's further care and treatment were not based on all relevant considerations. The doctors' care and treatment of Mr M fell so far below what they should have been that they amounted to service failure.

There were shortcomings in some aspects of the care and treatment the Trust provided for Mr M during his second admission. As the Trust had already acknowledged, communication with Mr M and his family did not meet the family's needs. The family did not get important information they needed in a way they could understand at what must have been a very difficult time. Mr M was discharged without getting the medication he should have had.

However, taken as a whole, the care and treatment Mr M received during his second admission did not fall so far below what they should have been that they amounted to service failure.

We could not imagine the shock and distress Mrs M and her family suffered as a result of her husband's sudden deterioration and death, but we could not conclude that the outcome for Mr M would have been different. It was likely that he would not have survived even if everything that should have been done, had been done.

We recognised, however, that if Mr M's cancer had been diagnosed sooner, Mr M and his family would have had the opportunity to be involved in deciding how his cancer would be managed and they would have had the opportunity in those last few months to prepare themselves for the end of Mr M's life. The fact that Mr M and his family did not get these opportunities was an injustice to them.

Putting it right

The Trust acknowledged and apologised for its failings. It also paid Mrs M £1,500 as a tangible acknowledgement of the injustice her husband and her family had suffered. The Trust created an action plan that showed learning from its mistakes so that they would not happen again.

Organisation(s) we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 667/December 2014

Daughter complained about her late father's care

Ms H complained that GPs did not fully consider her father's symptoms to see if he needed to be admitted to hospital.

What happened

Mr A had a number of health concerns. GPs used to visit him at home when he could not go to the Practice.

Ms H complained that during these home visits, the GPs did not fully consider Mr A's symptoms to see if he needed to be admitted to hospital. She said that Mr A later fell at home twice and was admitted to hospital each time. Ms H felt that if the doctors had properly assessed her father, he would have been admitted earlier and the falls at home avoided.

On the second admission to hospital, Mr A died.

What we found

We partly upheld this complaint. The GP home visits and assessments were generally thorough, and on the whole did not indicate Mr A needed to go to hospital. However, in the light of Mr's A conditions and symptoms, which included feeling faint, the GPs should have checked his blood pressure. The correct sized blood pressure cuffs were not available at the time of these home visits.

Practice staff could have acted on a blood test result sooner, and doctors could have considered admitting Mr A to hospital, but he was taken to hospital later that day.

Overall, we did not consider that these issues would have prolonged Mr A's life.

Putting it right

The Practice acknowledged and apologised for the failings. It also reviewed its training for all clinical staff around blood pressure checks and blood test identification. The Practice is investing in additional blood pressure cuffs. One GP agreed to discuss our report at her annual appraisal.

Organisation(s) we investigated

A GP practice

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 668/December 2014

Missed diagnosis of rare condition did not affect patient's chances of survival

Failings in Mr B's care led to the misdiagnosis of a rare acute cardiac condition. However, it is likely his condition had already progressed too far by the time he was first seen in A&E and so his death could not have been avoided.

What happened

Mr B went to the Trust's A&E department with abdominal pain on three occasions over just a few days. The first time, he was diagnosed with a suspected kidney stone that had passed and staff discharged him. Mr B's GP referred him to A&E two days later. Staff in A&E then diagnosed an underactive thyroid and obstructive sleep apnoea (when breathing stops for short spells during sleep), and Mr B was again discharged.

Mr B's GP referred him to A&E a third time, and he was admitted to hospital for investigation. After tests, doctors made the correct diagnosis of aortic dissection (a tear in the wall of the aortic artery) and Mr B had emergency surgery. He continued to deteriorate, and further surgery found the blood supply to Mr B's bowel had been affected by the dissection. Unfortunately, Mr B did not recover after the surgery and he died within a few days.

What we found

We partly upheld this complaint. When Mr B first went to A&E, staff assessed, examined and reviewed him in the correct timescales. They arranged the right observations, tests and scans on the basis of his symptoms and the suspected diagnosis. Although the first diagnosis was incorrect, it was a reasonable working diagnosis, given the information doctors had at the time.

There were failings by the Trust during Mr B's second visit to A&E. The doctors did not link his symptoms, including low blood pressure, and this meant that Mr B was discharged instead of being sent to the medical and cardiology teams for further investigation.

During his third visit to A&E, Mr B's care was carried out by the A&E teams. This is contrary to an agreement by the College of Emergency Medicine that patients returning to A&E within 72 hours should be seen by a senior doctor. That said, the A&E team made a reasonable diagnosis, and Mr B was admitted for investigations that led to the correct diagnosis of aortic dissection.

Mr B and his family were distressed by his repeated visits to A&E. However, it was more likely than not that by the time Mr B first went to A&E, the aortic dissection had progressed so far that it had already affected the blood supply to his bowels. We were not able to say that Mr B's death could have been prevented, even if the correct diagnosis had been made earlier.

Putting it right

As the Trust had already completed a serious incident investigation report and action plan, we asked it to update the action plan to address the failings we had identified. It agreed to do so and to share the updated plan with Mrs B, the Care Quality Commission and Monitor.

Organisation(s) we investigated

King's College Hospital NHS Foundation Trust

Location

Greater London

Region

London

Summary 669/December 2014

Practice misdiagnosed woman's condition, putting her at unnecessary risk

Miss L was diagnosed with a condition that she did not have. She was put at an unnecessary risk of side effects from medication.

What happened

A doctor at Miss L's GP Practice diagnosed her with lupus and prescribed medication for this condition. Although the medication needed to be monitored regularly because of potential side effects, the Practice did not review Miss L. It also did not provide the bone protection that is recommended when a patient is taking this medication, and did not review the medication for 18 months. It did not refer Miss L to a specialist until two years after her original diagnosis. The specialist found she did not have lupus.

What we found

Miss L did not have enough key indicators or symptoms to suggest that she had the condition. The Practice's diagnosis was not in line with established good practice or relevant clinical guidelines. The Practice's poor management of her medication was a failing in care. Not referring Miss L to a specialist in good time was also a failing. Miss L's medical records were also not detailed enough.

Putting it right

The Practice apologised to Miss L for the mistakes it had made. It also paid her £250 to recognise the impact that these had on her, and reimbursed her the £14.40 she had spent when she asked for her medical records.

The Practice agreed to put together an action plan to show it had learnt from its mistakes so that they would not happen again, and to audit its medication policy. The GP who made the diagnosis agreed to review her understanding of the condition and learn more about it.

Organisation(s) we investigated

A GP practice

Location

Essex

Region

East

Summary 670/December 2014

Nursing staff delayed giving medication and pain relief to terminally ill cancer patient

Mrs R felt nursing staff were uncaring and dismissive of her daughter's pain, so her pain relief was delayed. Her daughter also did not get medicine to prevent sickness after her chemotherapy.

What happened

Miss R was in her twenties and had been diagnosed with terminal cancer. She went to A&E with severe pain. Staff gave her pain relief and discharged her home the same day.

Miss R was admitted to hospital a few days later because her condition had got worse and her pain was uncontrolled. Staff gave her palliative chemotherapy, which made her severely sick. Mrs R believed this weakened her daughter. The ward doctor said that Miss R had not been given the antisickness medication she should have had after the chemotherapy. Miss R continued to be in pain and regularly asked for more pain relief. She died in hospital from her cancer.

In addition, Mrs J complained about the attitude of a doctor in A&E who, she claimed, said Miss R was addicted to medication.

What we found

We partly upheld this complaint. Although there was an appropriate plan in place to manage Miss R's pain, there were times when nursing staff did not respond quickly enough when she said she was in pain. We could not find out why Miss R did not receive her antisickness medication after the chemotherapy, but something had clearly gone wrong for this to happen. As a result of this, Miss R suffered avoidable pain and sickness. This distressed her and her family.

There was no evidence to support Mrs R's concerns about the A&E doctor.

Putting it right

The Trust wrote to Mrs R to apologise for the failings in her daughter's pain relief and antisickness medication, and for the distress these had caused. It also explained what processes it has put in place since to prioritise pain management on its wards.

Organisation(s) we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 671/December 2014

GP practice sent patient an unreasonable warning

A patient complained that the warning he received from his GP Practice made unfair allegations about his behaviour.

What happened

Mr H visited the Practice to get a medical report for his son. He was told the report had not been completed and that it could not be completed until the Practice manager returned from leave. Mr H told staff he was unhappy with this, and they eventually gave him the report.

The following week Mr H received a letter from the Practice manager warning him about '*intimidation and demanding behaviour*'. Mr H complained to staff about the letter. The Practice got a number of statements from staff and said these referred to his '*intimidating manner, aggressive tone*'.

Mr H decided to move to a different GP practice. He then met with the first Practice to discuss the issue, but neither party felt this resolved anything, and so he complained to us.

What we found

The Practice did not gather written statements from staff until after Mr H made a formal complaint. Although some of the statements made reference to Mr H being '*threatening*' and '*verbally abusive*', we found no evidence to support this.

The only recorded comments in the statements provided to us were that Mr H said: '*that's unacceptable*' and '*incompetence*'. We therefore did not agree that this showed Mr H had been threatening or verbally abusive. If the Practice had simply warned Mr H that staff had been intimidated by his manner, this would arguably have been reasonable. However, its warning made allegations about his behaviour that were not supported by the evidence.

The basis of the warning given to Mr H was therefore unreasonable.

Putting it right

The Practice apologised to Mr H and also wrote to his new Practice to make it aware of this.

Organisation(s) we investigated

A GP Practice

Location

Nottinghamshire

Region

East Midlands

Summary 672/December 2014

Unreasonable delay in dealing with urgent referral

Ms C experienced an unreasonable delay after her GP referred her to the Trust's community mental health team.

What happened

Ms C's GP referred her for an urgent assessment by the Trust's community mental health team. Although the referral was urgent, the community mental health team took three weeks to see Ms C. Ms C said that she had to take an extended period of sick leave which she attributes to the poor service she received.

What we found

The Trust did not make enough attempts to contact Ms C, and it was three weeks before someone from the community mental health team saw her. The Trust's own protocol required staff to contact a patient within seven days of an urgent referral. The unreasonable delay caused Ms C distress and anxiety, but we could not link these failures with Ms C's absence from work for two months.

The Trust was open and honest in its response to Ms C. It acknowledged its failure to see her sooner and said that it would take action to improve its service. However, this was not followed up, and we saw no evidence of learning by the Trust. We therefore upheld Ms C's complaint.

Putting it right

Since the events in question, the community mental health team management has changed. In order to reassure Ms C, we recommended that the Trust write to her, giving details of changes made in the way the community mental health team deals with urgent referrals, and how these will prevent a recurrence of her experience. The Trust did this. It also paid her £500 in recognition of the distress, uncertainty and loss of confidence in the service Ms C experienced.

Organisation(s) we investigated

Sussex Partnership NHS Foundation Trust

Location

West Sussex

Region

South East

Summary 673/December 2014

GP failed to respond to a written complaint

The GP Practice should have written to Ms D to explain she was a temporary patient. It then mishandled her complaint about this.

What happened

Ms D wrote to her GP Practice to complain that it did not tell her about her status as a temporary patient, which led to her being excluded from funding for fertility treatment. In consequence, she had to fund two unsuccessful rounds of fertility treatment herself.

Because Ms D had already written to the Practice with a slightly different complaint, the Practice took the view that it had dealt with her concerns already. She received a letter in response that said the Practice was satisfied there was no further complaint to answer.

What we found

We partly upheld this complaint. The Practice was not obliged to warn Ms D that she was a temporary patient at its surgery because she was already a permanent patient at another Practice. Because of this, the GP Practice was not responsible for her ineligibility for fertility treatment funding. It should have written to her to explain this.

Its letter to say it had already dealt with this issue was inaccurate.

Putting it right

The Practice apologised to Ms D for not addressing her latest complaint.

Organisation(s) we investigated

A medical centre

Location

Essex

Region

East

Summary 674/December 2014

Poor response to concerns about GP care at residential care home

A GP Practice provided reasonable care and treatment to an older patient with dementia. However, the Local Area Team's response to the complaint failed to adequately address concerns the patient's wife raised.

What happened

Mr P suffered from Lewy bodies dementia, a type of dementia. As his condition deteriorated, Mr P was moved to a residential care home in a different county where he was under the care of a local GP.

Mr P's wife was concerned that during Mr P's stay at the care home, he had lost weight, suffered recurrent urine infections and developed pressure sores. Mrs P asked for him to be referred to mental health and geriatric specialists. Sadly, Mr P died of a pulmonary embolism before he could be seen by a geriatrician.

Mrs P complained to the Local Area Team in autumn 2012. During the course of its investigation the Local Area Team referred the case for an independent GP review. This was completed at the end of 2012.

In spring 2013 the Local Area Team wrote to Mrs P with its formal response. She complained to us that this failed to satisfactorily address her concerns about the GP's care of her husband, and that her requests for him to be seen by a specialist were not taken seriously or acted upon in good time.

What we found

The care and treatment the GP provided was reasonable. However, the Area Team's response to the complaint did not properly address Mrs P's concerns. This caused Mrs Mann further frustration which had not been remedied.

Putting it right

The Area Team apologised to Mrs P for failing to address her concern about the lack of specialist involvement from a geriatrician.

Organisation(s) we investigated

Hertfordshire and the South Midlands Area Team

Location

Hertfordshire

Region

East

Summary 675/December 2014

Low-risk patient had stroke when taken off medication to thin his blood

The Trust was correct to say there was no clear research evidence of the best way to balance the risk of bleeding against the risk of blood clots and stroke.

What happened

Mr B suffered from atrial fibrillation (a fast and erratic heartbeat) and was taking medication to thin his blood. He needed a colonoscopy (an examination of the inside of the colon), and a week before he was due to have the procedure the Trust told him to stop taking warfarin (an anticoagulant that slows the rate at which blood clots). Mr B had a stroke the day before he was due to have the procedure. This left him with slurred and slowed speech.

Mr B complained to the Trust. It told him that he had been a low-risk patient and it had followed its standard practice in advising him to come off warfarin for seven days. It was sorry for his situation.

The Trust explained there was a national debate about the best way to balance the risks for patients on warfarin who needed a colonoscopy. When doctors do a colonoscopy, they sometimes need to remove polyps (growths on the lining of the colon) at the same time. Warfarin increases the risk of bleeding during this procedure. There was no clear research evidence of the best way to balance the risk of bleeding against the risk of blood clots and stroke.

What we found

We did not uphold this complaint, although we had every sympathy with Mr B's situation. The Trust had followed its local policy, which was within the range of good practice from a clinical perspective. There are national guidelines that state that a patient should only come off warfarin for five days before an endoscopy (a colonoscopy is a type of endoscopy). However, other guidelines were less clear cut and the Trust's rationale for deciding on a seven-day period was not unreasonable. The Trust was correct to say that there was no definitive evidence of the best way to balance the risks. This was a very difficult set of issues from a clinical point of view.

It was not possible to say whether being off warfarin caused the stroke, as a small proportion of patients will have a stroke even though they are on anticoagulants. Mr B was placed at a slightly increased risk as a result of being off warfarin for seven days rather than five, but it was not possible to be specific about that. In addition, warfarin needs to be taken for several days to become fully effective. Even if it had been restarted on day five, it would not have fully taken effect by the time Mr B had his stroke.

Putting it right

The Trust agreed to produce an information leaflet for patients who took warfarin and who were to have endoscopic procedures. It also agreed to write to Mr B again to acknowledge his situation and express its sympathy.

Organisation(s) we investigated

University Hospital Southampton NHS Foundation Trust

Location

Southampton

Region

South East

Summary 676/December 2014

NHS England did not acknowledge delays in continuing care assessment

Mrs D's family complained about the decision not to award their mother continuing healthcare funding. They also said that there had been significant delays in the decision-making process.

What happened

In spring 2012 Mrs D's family appealed their local Primary Care Trust's (PCT) decision to refuse continuing healthcare funding for their mother. The PCT did not uphold the appeal, and sent Mrs D's family clarification of its decision in summer 2012. The family then asked NHS England to independently review the decision.

The review was initially delayed for one month because the PCT told NHS England that the local appeals process was not complete. There was then a nine-month delay before the PCT gave NHS England all the information it needed for the review.

NHS England upheld the PCT's decision that Mrs D was not eligible for continuing healthcare funding, and her family complained to us.

What we found

We partly upheld the complaint. There was no fault in NHS England's decision that Mrs D was not eligible for continuing healthcare funding. However, we were critical of NHS England for not acknowledging the unnecessary delays in the process. Although we did not consider that the delays had been caused by NHS England's actions, we concluded that it should have acknowledged the delays and remedied them in the independent review.

Putting it right

As a result of our findings, NHS England apologised to Mrs D's family and explained how it had improved its processes.

Organisation(s) we investigated

NHS England's Midlands and East of England Commissioning Region

Location

Cambridgeshire

Region

East

Summary 677/December 2014

Failings in communication at rehabilitation hospital

Ms B's partner, Mr K, suffered a cardiac arrest and had a brain injury that meant he needed rehabilitation in hospital. Ms B became unhappy when staff treated her with suspicion.

What happened

Ms B was unhappy because when Mr K was transferred from one ward to another, staff supervised her visits, her weekend visits were cancelled and she was no longer involved in Mr K's care, or updated about his progress.

When social workers visited Ms B at home, with a view to reinstating Mr K's home visits, she felt they were treating her with suspicion. She was made to feel uncomfortable in her own home.

What we found

We partly upheld this complaint. The hospital had already recognised that staff treated Ms B with unfounded suspicion, and that staff did not follow procedures when transferring Mr K between wards. This, together with failings in communication, led to a breakdown in trust. As a direct result of this, when social workers visited Ms B at home, the purpose of the visit was lost and Ms B was left feeling upset and distressed.

We could not say that these failings led to a breakdown in Ms B's relationship with Mr K, but we thought that the hospital had not done enough to recognise the impact these events had on her personally.

The hospital had not gone far enough to reassure Ms B that lessons had been learnt from her complaint.

Putting it right

The hospital apologised to Ms B for the upset and distress she suffered as a result of failings already accepted, and paid her £500 in recognition of this.

It also explained what actions it was taking to make sure that relevant policies and procedures are being properly implemented and monitored.

Organisation(s) we investigated

St Andrew's Healthcare Group of Hospitals

Location

Northamptonshire

Region

East Midlands

Summary 678/December 2014

Unexplained delays in outpatient clinics and inappropriate comments in medical records

Mrs Y complained about delays at two outpatient clinics. She also said that comments in her records were inaccurate and should be redacted.

What happened

Mrs Y went to an allergy clinic. Staff at the clinic referred her to a dermatology clinic for patch tests to find out if she had an unidentified allergy. She said there were delays of nearly three hours at the first clinic and two hours at the second.

The Trust responded swiftly to Mrs Y's complaint about the first clinic. But although her experience at the second clinic was almost identical, staff did not explain the reason for the delay.

A doctor made a number of comments in her medical records that Mrs Y felt were inaccurate and defamatory. Mrs Y also complained about a delay in staff carrying out her patch tests and the manner in which the Trust responded to her complaint.

What we found

We partly upheld this complaint. The Trust did not explain the delays properly or outline the measures it was taking to improve patients' experience.

The Trust's complaint handling was below the standard we would expect.

We felt that the Trust had arranged for the patch tests to be carried out within a reasonable timeframe.

Putting it right

The Trust apologised to Mrs Y for its mistakes and agreed to draw up plans to prevent the same things happening again.

The Trust told Mrs Y about what it had done to improve patients' experience. It also changed her medical records in line with our recommendation.

Organisation(s) we investigated

Mid Essex Hospital Services NHS Trust

Location

Essex

Region

East

Summary 679/December 2014

Trust could have given patient more information when she complained

Mrs F had complications after a gastric band operation, and complained to the Trust. Her treatment was correct but the Trust could have done more to keep her up to date about her complaint.

What happened

Mrs F had a gastric band operation in 2011. Trust staff repeatedly found evidence of infections at later outpatient appointments and treated these with antibiotics. However, as the infections kept returning, staff removed the access port (a device that gives clinicians access to the gastric band) that doctors had inserted as part of the procedure. Staff took the access port out in spring 2011 because they thought it might have been a source of the infections.

Trust staff carried out an investigation of Mrs F's gastric band two months later. This found no problem with the band. But another investigation some six weeks afterwards showed the band had eroded, and doctors decided to remove it. Mrs F complained that staff should have done more at an earlier stage to find the cause of her infections.

What we found

We partly upheld this complaint. There was no fault in Mrs F's clinical care. However, there was a delay in complaint handling, during which time the Trust did not give Mrs F enough information about progress.

Putting it right

The Trust apologised to Mrs F.

Organisation(s) we investigated

Taunton and Somerset NHS Foundation Trust

Location

Somerset

Region

South West

Summary 680/December 2014

Patient wanted a trust to pay for a scan he had arranged

Mr B complained that the Trust did not offer him an MRI scan for an ankle injury, so he paid for one himself.

What happened

Mr B injured his ankle while playing football. The next day he went to see his GP, who referred him to the local A&E department. Mr B had an X-ray that did not show a fracture. The emergency nurse practitioner diagnosed a soft tissue injury, a term that includes an ankle sprain. The nurse gave Mr B advice about this and told him to return if his condition got worse.

The emergency nurse practitioner also offered follow-up physiotherapy but Mr B declined this as he already had his own private physiotherapist. Mr B then arranged a private MRI scan himself, which cost him £320. He wanted the Trust to repay this.

Mr B also complained about inaccuracies in the Trust's response to his complaint. The response misidentified Mr B's place of work and wrongly stated that a medical professional had arranged his MRI scan.

What we found

We did not uphold Mr B's complaint. The care and treatment the Trust gave Mr B was appropriate and in line with established good practice. The Trust was correct not to offer him an MRI scan for the type of injury he had.

The results of Mr B's private MRI scan were consistent with a diagnosis of a sprained ankle.

The Trust acknowledged that the reference to Mr B's place of work was an administrative error. It also told us that it is unusual for a scan to be arranged directly by a patient, so it had assumed that Mr B's GP made the referral.

The Trust's explanation for these minor administrative errors was reasonable and we did not consider that these mistakes were so serious that they were failings.

Organisation(s) we investigated

Harrogate and District NHS Foundation Trust

Location

North Yorkshire

Region

Yorkshire and the Humber

Summary 681/December 2014

Shortcomings in care and poor communication by Trust

Mrs L complained that her father, Mr K, received inadequate care and treatment. She believed this contributed to his kidney failure and death.

What happened

Mr K, who was in his eighties, went into hospital at the Trust in early spring 2012 because his family thought he might have had a stroke. Doctors treated him for heart failure. Mr K had a heart attack two weeks later, for which he had further treatment. Trust staff discharged him two weeks after that.

Some two months later, Mr K was readmitted to the Trust because he was short of breath. Staff treated him and discharged him two days later. A few hours after he got home, Mr K went back into hospital because he was increasingly breathless. Over the next few days, Mr K's liver and kidney function deteriorated and he died ten days later.

Mrs L said staff did not monitor Mr K adequately or give him medication at the right time. She felt that staff did not always communicate well with Mr K's family.

What we found

We partly upheld this complaint. The Trust gave Mr K satisfactory medical care in early spring 2012, but doctors did not communicate adequately with other staff before Mr K was discharged. At times, doctors did not communicate enough with his family.

Although the decision to discharge Mr K in the summer was reasonable, he was left unmonitored for two and a half hours before he went home.

The Trust did not follow National Institute for Health and Care Excellence guidelines, a doctor did not assess Mr K in A&E when he went into hospital in the summer, and doctors did not provide medication or keep records in line with General Medical Council guidance.

The improvements the Trust had already made in nursing care addressed the issues that Mrs L complained about.

Putting it right

The Trust apologised to Mrs L. It agreed to give her information about the improvements it had already made and to prepare an action plan that described what it had done to make sure that it has learnt the lessons from the failings we highlighted.

Organisation(s) we investigated

Surrey and Sussex Healthcare NHS Trust

Location

Surrey

Region

South East

Summary 682/December 2014

GP practice failed to deal with woman's abdominal symptoms at an early stage

Ms J complained that her GP Practice misdiagnosed her appendicitis, which delayed treatment. She felt that she lost an ovary because of the delay, and she was also unhappy about the Practice's complaint handling.

What happened

Over seven months, Ms J saw various GPs at the Practice with ongoing pain in her lower abdomen and side. Doctors diagnosed her with a urinary tract infection, constipation, stress and irritable bowel syndrome.

Ms J developed appendicitis and went into hospital, where clinicians removed her appendix. Surgeons also removed one of her ovaries, which had become gangrenous. The gangrene was caused by a cyst that had become wrapped around Ms J's fallopian tube and cut off its blood supply.

Ms J was dissatisfied by the Practice's response when she complained, so she came to us. She was concerned that losing one ovary meant she should start a family as soon as possible and she wondered whether she would start her menopause early.

What we found

The Practice should have carried out tests and referred Ms J earlier for investigation of her symptoms. The Practice had not ruled out other causes of Ms J's symptoms before it gave her a diagnosis of irritable bowel syndrome.

Our gynaecology adviser said that the loss of one ovary would not reduce Ms J's fertility, and there was no evidence that having one ovary meant the menopause would start earlier than otherwise. The Practice had included this information in its response to Ms J's complaint.

Putting it right

The Practice apologised to Ms J and acknowledged the failings we found. It also put a plan in place to make sure lessons were learnt from what had happened.

Organisation(s) we investigated

A GP practice

Location

Essex

Region

East

Summary 683/December 2014

Shortcomings in nursing care and complaint handling

Mr D complained about the quality of the medical and nursing care he received as an inpatient at the Trust in 2013. He was also unhappy about how the Trust handled his complaint.

What happened

Mr D went to hospital expecting to have a non-invasive treatment for kidney stones. However, staff carried out a different, more invasive procedure. Mr D felt that the medical treatment he received caused long-standing physical problems. He also complained about his nursing care, especially the removal and reinsertion of catheters, when he was recuperating from surgery.

Mr D also said that Trust representatives were unprepared when they went to a complaint resolution meeting with him.

What we found

We partly upheld this complaint. Mr D's kidney stone treatment was reasonable and in line with accepted practice.

There were serious shortcomings in how staff removed a catheter and in the way they monitored his health after his operation. There were shortcomings in how staff monitored Mr D's blood pressure because they did not follow the Trust's own guidelines.

Trust staff were unprepared when they went to a resolution meeting with Mr D.

Putting it right

The Trust apologised to Mr D for the shortcomings outlined in our investigation.

It drew up plans to improve training in removing catheters from male patients and to improve monitoring of patients' blood pressure. It also committed to making sure that staff who go to meetings with complainants are properly prepared.

Organisation(s) we investigated

Walsall Healthcare NHS Trust

Location

West Midlands

Region

West Midlands

Summary 684/December 2014

Midwives failed to properly support a woman's choice of home birth because of her epilepsy

Midwives told a woman with epilepsy that her baby would be born with breathing difficulties and said that she should give birth in an obstetric unit although she wanted a home birth.

What happened

Mrs F has epilepsy and takes medication for this. Her first baby was born at home. The baby briefly went into hospital but was discharged the same day. During her second pregnancy, midwives repeatedly advised Mrs F that she should give birth in an obstetric unit because of risks to her baby from her epilepsy medication. The midwives gave this advice without seeking information from a specialist consultant first. Mrs F was also told that her baby would be born '*barely breathing*' because of her medication.

What we found

We partly upheld this complaint. There were some failings in the care Mrs F received.

The midwives did not support Mrs F's decision to have a home birth. They based their advice on incorrect assumptions about the risk posed by Mrs F's epilepsy medication. The delay in seeking the opinion of a consultant obstetrician was not good practice.

These failings meant that Mrs F was stressed during her pregnancy. Mrs F was also unsure about seeking midwifery care from the same midwife team for the birth of her third child, and so went elsewhere for this.

Putting it right

The Trust apologised to Mrs F for these failings. It prepared an action plan to avoid a recurrence, and reviewed its policies for women requesting care outside guidelines.

Organisation(s) we investigated

University Hospitals of Morecambe Bay NHS Foundation Trust

Location

Cumbria

Region

North West

Summary 685/December 2014

Hospital missed opportunity to try to save patient's fallopian tube

Miss F had an ectopic pregnancy, a pregnancy outside the womb. When her condition got worse, the Trust only gave her one treatment option and she lost a fallopian tube.

What happened

Miss F went to an early pregnancy clinic with abdominal pain after a positive pregnancy test. Staff scanned her but could not see a pregnancy in her uterus. Clinicians became concerned that Miss F had an ectopic pregnancy. They referred her to a consultant, who was also unable to see a pregnancy when she carried out a scan.

The consultant made a working diagnosis of early ectopic pregnancy or pregnancy of unknown origin. She advised Miss F to have an injection to stop the pregnancy. Before Miss F could have this, she suffered severe abdominal pain and vaginal bleeding. Trust staff operated and removed a fallopian tube, although it had not ruptured. Laboratory tests found no evidence of pregnancy in the tube.

What we found

We partly upheld this complaint. Miss F came to us with a number of issues. We felt that the Trust had done everything it should have to establish if Miss F had a viable pregnancy. It had correctly advised her to have an injection to stop the pregnancy growing.

However, when Miss F had severe pain and bleeding, staff should have offered her two options, not just one. She should have had the option of an alternative procedure that might have meant that doctors would not have removed her fallopian tube. However, there is no certainty that the tube could have been saved. As a result of what happened, Miss F is left with doubt that everything that could have been done to try to save her fallopian tube was done, as she had wanted.

Putting it right

The Trust apologised for the failings and the impact they had. It paid Miss F £3,000 to acknowledge the upset it had caused her.

Organisation(s) we investigated

Heart of England NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 686/December 2014

Failure to check CCTV meant man could never know if Trust lost his belongings

Mr K was taken to A&E after he was found unconscious. He believes he had property when he arrived in A&E and it was lost during his stay. The Trust said he did not have the property when he was at the Trust.

What happened

Mr K went to A&E after he was found unconscious in the street with a head injury. He was taken to the Trust in an ambulance. Mr K left the Trust the following morning without his jacket, glasses and mobile phone. Mr K believed he had these belongings while he was in A&E. The Trust said he arrived without a jacket and it had no record of his glasses or mobile phone, although one member of staff said she thought she remembered seeing him with a mobile phone.

What we found

We partly upheld this complaint. There were no failings in how the Trust managed Mr K's belongings. However, when Mr K complained to it about his missing property, it missed an opportunity to access CCTV footage to resolve this complaint one way or another, although Mr K had asked it to do this.

Putting it right

The Trust apologised to Mr K for the missed opportunity to give him answers, and reviewed its approach to complaint handling to make sure it accessed CCTV if this was available and would help deal with a complaint, in future.

Organisation(s) we investigated

St Helens and Knowsley Teaching Hospitals NHS Trust

Location

Cheshire

Region

North West

Summary 687/December 2014

Maternity record confusion when Trust did not identify patient correctly

Mrs B complained that the Trust confused her records with a family member's during her labour. When staff realised the mistake, they did not take action to correct the records.

What happened

Mrs B gave birth to her son at the Trust. Staff did not correctly identify her and confused her records with those of a family member, who was also pregnant but not due to give birth for several months.

After the birth of Mrs B's son, staff realised the mistake. Mrs B thought that the Trust had then amended its records. However, the Trust sent a letter about Mrs B's care to her relative and sometime later, Mrs B realised that a blood test taken at the time of her labour, which showed some abnormalities, had been recorded in her relative's notes.

What we found

We partly upheld this complaint. Mrs B complained to the Trust each time a new issue arose as a result of the incorrect records. We found the Trust had not taken action to address the cause of the initial failing or make sure that the records were correct.

Putting it right

The Trust apologised for its failings and paid Mrs B compensation of £400. It prepared an action plan to make sure the error was corrected and that there was learning from the complaint.

Organisation(s) we investigated

University Hospitals of Leicester NHS Trust

Location

Leicester

Region

East Midlands

Summary 688/December 2014

Trust did not provide aftercare information but gave nursing care to the right standard

When Mrs P went into hospital, Trust staff did not help her when she had unexpected symptoms or record what had happened. She was also unhappy about the information staff gave her when she went home.

What happened

In 2013 Mrs P had throat surgery in hospital at the Trust. Trust staff discharged her home the next day.

While Mrs P was in hospital, she was incontinent and bled vaginally. Nursing and medical staff did not address either of these issues. When Mrs P went home, staff did not give her any aftercare information about her throat operation, so she had to visit her GP. Mrs P told us she was stressed by what happened and had lost faith in the service given by the NHS.

The Trust apologised for the distress and upset caused to Mrs P. It said she had been cared for appropriately when she was in hospital, and told her about the steps it would take to address the issues around the lack of aftercare information.

What we found

We partly upheld this complaint. We concluded that while there were failings around the lack of aftercare information, and staff recorded information about Mrs P's incontinence and vaginal bleeding poorly, we were unable to link these failings to the injustice she claimed.

We were satisfied that the failings would be resolved when the Trust implemented our recommendations.

Putting it right

The Trust acknowledged and apologised for its failings. It drew up an action plan to prevent similar problems in future.

Organisation(s) we investigated

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 689/December 2014

Trust did not give patient clear advice to get a referral from her GP

Mr J complained that staff at the Trust did not tell his wife to report her symptoms of bleeding to her GP. He said that the Trust failed to consider her symptoms properly, which led to a delay in her diagnosis of cancer, and treatment for it.

What happened

Mrs J, who was in her seventies, had vaginal bleeding in spring 2012. This was treated at the Trust's gynaecological outpatient clinic. She had another episode of bleeding three months later, in summer 2012. She told staff at the gynaecological outpatient clinic and nurses suggested that she could either go back to the clinic or see her GP if she continued to have problems.

In autumn 2012, Mrs J was still bleeding and a nurse at the clinic advised her to go to her GP. Her GP referred her to a fast-track clinic at the Trust, and in late autumn 2012, Trust staff diagnosed her with endometrial cancer. Unfortunately Mrs J was ill and was unable to have surgery until early 2013, by which time the cancer had spread and could not be treated with surgery.

Mrs J died in mid-2014.

What we found

We partly upheld this complaint. The Trust appropriately treated Mrs J's bleeding in spring 2012. However, when Mrs J continued to report bleeding in summer 2012, nurses should have given Mrs J clear and unequivocal advice that she needed to see her GP. Her care fell below an acceptable standard and was service failure.

We did not find that the Trust should have made a referral for diagnosis in the period between spring and summer 2012. There was then a delay of six weeks, during which time Trust staff could have told Mrs J to see her GP. Mrs J's cancer was still operable at the time of diagnosis in autumn 2012.

The Trust's delay, no matter how short, did not give Mrs J the best possible chance of receiving treatment at the earliest possible stage.

The Trust said it has changed its process to make sure that if a patient presents with vaginal bleeding, staff will give her cream to treat this for two weeks. If the bleeding does not settle, staff will monitor the patient as instructed by a doctor. The Trust said if bleeding continued it would usually carry out an ultrasound scan. We considered that the action the Trust took will strengthen this process. However, the Trust had not acknowledged the impact of its failings.

Putting it right

The Trust had already improved its procedures to prevent a recurrence of the events that led to Mr J's complaint. It wrote to Mr J to apologise for the failings we found.

Organisation(s) we investigated

Barnsley Hospital NHS Foundation Trust

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 690/December 2014

Poor care and delays in transferring acutely ill older patient caused distress

When Mrs H went into the Trust's mental health unit, her family became worried about her care.

What happened

Mrs H, who had dementia, went into the Trust's mental health unit for just over five weeks. During this time, her family raised concerns about the care provided. They said that a lack of appropriate observation and support by staff put Mrs H at risk from other patients on the unit. In the last few days of her admission, Mrs H's physical health deteriorated and she was eventually transferred to the neighbouring acute hospital, where she died some days later.

Mrs H's family continued to raise concerns about the care the Trust had given, including that a delay in transferring Mrs H to the acute hospital contributed to her death. Family members were concerned that a number of relevant records were missing, while other records were completed inaccurately. Delays and errors in the Trust's complaint handling further distressed the family.

What we found

We partly upheld this complaint. The Trust's communication with Mrs H's family was not always clear and effective, although we did not find that this was so significant that it amounted to a failing. However, there were a number of shortcomings in the care given to Mrs H, including in recording her general and vital sign observations; recording the medication given; and recording bruising, and investigations into what caused this. There was also an unreasonable delay in initiating Mrs H's transfer to the acute hospital. There were also failures in the Trust's complaint handling.

We could not say these failings caused, or contributed to, Mrs H's deterioration, or led to her death. However, they distressed her family and meant that family members were not reassured that Mrs H's care was appropriate. The family's distress was exacerbated by the poor complaint handling.

Putting it right

The Trust wrote to Mrs H's family to recognise, acknowledge and apologise for the failings we found in her care and in how it had handled the complaint. It paid Mrs H's family £750 to recognise the distress caused.

It created an action plan to demonstrate the learning it took from the complaint and the actions it would take to address its failings.

Organisation(s) we investigated

Kent and Medway NHS and Social Care Partnership Trust

Location

Kent

Region

South East

Summary 691/December 2014

Trust did not give correct pain relief in A&E

Mrs B complained to us that she did not get appropriate care and treatment when she went to the Trust's emergency department several times in a year.

What happened

Mrs B had to go to the Trust's emergency department several times over the course of a year for pain relief. Her pain was caused by a long-standing condition, and it could not always be controlled outside a hospital setting. When her condition became extremely painful, she had to go hospital for pain relief. Mrs B complained to us about the difficulties and delays in getting pain relief when she arrived at the emergency department.

What we found

We partly upheld this complaint. Because of Mrs B's numerous visits to the emergency department for the same reason, the Trust should have had a management plan in place for her. It did not. Consequently, it was not clear to staff how they would treat Mrs B's pain each time. She was given pain relief that was not right for her particular condition.

Putting it right

By the time she complained to us, Mrs B had had treatment that had stopped the episodes of pain. We recommended that the Trust consider a management plan if she goes back to the hospital with similar problems. The Trust paid Mrs B £250 to recognise the distress it had caused.

Organisation(s) we investigated

Stockport NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 692/December 2014

Trust and out-of-hours GP service failed to give good care

Mrs D complained that the GP out-of-hours service did not respond appropriately to her concerns about her husband. It did not offer a home visit or clearly explain her options when she called the service, and this led to delays in his treatment.

Mrs D also complained about the Trust's care and treatment of her husband. She felt his death one week after admission could have been avoided if he had had better care.

What happened

Mr D had dementia, but was independent and looked after himself. In summer 2011, Mr D's health deteriorated and his speech became slurred. His wife, Mrs D, called the GP out-of-hours service, which did not visit but arranged for Mr D to go to a minor injuries unit. Staff at the minor injuries unit diagnosed Mr D with a possible heart attack or a stroke. Clinicians gave him medication and sent him to A&E at the Trust by ambulance.

Trust staff called to ask Mrs D and her family to go to the hospital to meet a consultant. When Mr D's family arrived at hospital, they learnt that Mr D had experienced bleeding, a stroke and a heart attack, and had pneumonia. Staff said that his death was imminent.

Mr D continued to deteriorate. He developed acute heart failure. During Mr D's last few days, there were several discussions between clinical staff and his family about his condition and the appropriateness of withdrawing treatment. He died soon after.

Mrs D expressed her concern about her husband's care and treatment from both the GP out-of-hours service and the Trust. Her main worry was that her husband's death could have been avoided.

What we found

We partly upheld Mrs D's complaint about both organisations. The GP out-of-hours service doctor, in his call to Mrs D, did not take account of or explore the significant symptoms she described. He should have considered these symptoms and offered an urgent home visit, if not a 999 ambulance. It was not possible, however, to say what difference an earlier assessment by the GP out-of-hours service doctor would have made to Mr D. He would have gone into hospital sooner, but only by a few hours. Given that Mr D was very seriously ill when his wife first contacted the GP out-of-hours service, the effect of a delay of a few hours would have been minimal. We recognised, however, that there was an impact on Mrs D, who felt that her concerns had not been listened to. This was a source of avoidable anxiety and upset to her at a time when she was already distressed.

With respect to the Trust, there was no evidence of delay in initial treatment or failings in how staff communicated with Mr D's family about his condition, the withdrawal of treatment and their concerns about his treatment. However, shortcomings in Mr D's care meant that he had incomplete treatment for his heart attack and heart failure.

Although the medical management of Mr D's heart attack and heart failure could have been better, he nevertheless had some treatment for both. However, he continued to deteriorate. On the balance of probabilities, Mr D might have survived for a day or two longer had he received maximum treatment in line with recommended guidance. However, the severity of his illness meant his death at this time was not avoidable.

Putting it right

The GP out-of-hours service apologised to Mrs D and prepared an action plan to show what it had done to prevent a recurrence of the problems we found.

The Trust apologised to Mrs D for the failings in Mr D's care. It prepared an action plan to show what it had done to make sure that it had learnt the lessons from the failings we identified, and what the Trust had done or planned to do to avoid a recurrence of these failings.

Organisation(s) we investigated

North Bristol NHS Trust

A GP out-of-hours service

Location

Bristol

Region

South West

Summary 693/December 2014

Ambulance delay added to new mum's anxiety and distress after home birth complications

It took well over an hour for an ambulance to arrive when Ms W's midwife called 999.

What happened

Ms W gave birth at home. Everything was fine at first, however later that day she bled heavily and was uncomfortable. Her midwife visited and thought she had a prolapsed uterus. The midwife called 999 at 19.47 and again at 20.14, because an ambulance had not arrived. A clinical co-ordinator contacted the midwife at 20.24 and sent a paramedic in a rapid response vehicle to help until the ambulance arrived. The rapid response vehicle arrived at 20.51 and the ambulance arrived at 21.03 – one hour and 16 minutes later. Ms W was taken to hospital where she immediately had surgery. This was successful.

Ms W complained about the time it took for an ambulance to arrive, even though her midwife had made the seriousness of the situation clear in her 999 calls. Ms W was also concerned that the ambulance crew did not know where the hospital was.

The Trust responded to the complaint and carried out a serious incident investigation. It produced a root cause analysis report, which it shared with Ms W.

The Trust apologised to Ms W for what happened. It gave feedback to ambulance call handling staff regarding the errors they had made and the impact these had had. The clinical coordinator revised his approach to dealing with this type of call. In future, he will either talk to the healthcare professional sooner or will immediately upgrade the priority level of the call.

The serious incident investigation report made recommendations to address call handling errors and other issues, and the Trust acted on the recommendations.

What we found

We did not uphold Ms W's complaint because we consider that the Trust had fully acknowledged and apologised for what went wrong. We were satisfied that it had taken reasonable steps to put things right.

The Trust carried out a robust investigation and accurately identified the causes of the delay. It gave a reasonable explanation of why the crew were unsure of the best route to the hospital and how this was managed. It could have given additional assurance that crews have access to satellite navigation technology and can ask for support from the emergency operations centre if they need to.

The Trust did not realise that Ms W wanted compensation as one of the outcomes when it responded to her complaint. It therefore did not have the opportunity to consider this outcome. It agreed to consider compensation when it became aware of this and agreed to pay Ms W £350, the sum we identified as reasonable during our investigation.

Putting it right

The Trust paid Ms W compensation of £350.

Organisation(s) we investigated

East of England Ambulance Headquarters

Location

Cambridgeshire

Region

East

Summary 694/December 2014

Doctor's failure to accurately date pregnancy before termination procedure caused patient and family distress

Ms A consulted a doctor in the Trust's pregnancy counselling clinic about ending her pregnancy. When the doctor assessed Ms A, he did not date the pregnancy correctly.

What happened

The doctor relied on the last menstrual period date that Ms A gave him, although this date was not reliable, to date her pregnancy at eight weeks. The doctor did an ultrasound scan but did not measure the length of the foetus.

The doctor decided that Ms A could have a surgical termination procedure (vacuum aspiration) because the Trust's time limit for this procedure is 14 weeks. He assumed that the list of dates for surgical procedures, usually held a few days after the clinic, was going ahead. However, the list had been cancelled because of the holidays. Staff therefore scheduled Ms A's procedure for the following month.

On the day of the scheduled surgical termination, staff did an ultrasound scan and found that Ms A was over 16 weeks pregnant, so was over the time limit of 14 weeks for a surgical termination procedure. Ms A had to wait two days before a medical termination using drugs, (a labour-type delivery), could be done.

Some weeks later Ms A bled heavily. An ultrasound scan showed that some tissue from her pregnancy had remained in her womb. She went into hospital where staff removed this.

What we found

We took advice from an obstetrician/gynaecologist adviser. The doctor did not date Ms A's pregnancy by measuring the length of the foetus, which is what he should have done. In addition, the date the Trust gave Ms A was too long after her clinic appointment for a surgical termination. The Trust did not get it right, and this was service failure.

Because the Trust did not accurately date Ms A's pregnancy and offer her a termination procedure in good time, she had to have a medical, rather than a surgical, termination of pregnancy. The failings in Ms A's care caused deep distress to her and her parents. This was an injustice to them.

In addition, there is a greater risk of tissue from a pregnancy remaining in the womb after a medical termination, rather than a surgical termination. The Trust therefore put Ms A at higher risk of experiencing this. This was also an injustice to Ms A.

Putting it right

The Trust wrote to Ms A to acknowledge the service failure we found and the impact it had had on her and her parents. It paid Ms A and her family £2,500 to recognise the injustice caused to them.

We noted that following its own review of its actions in Ms A's case, the Trust has reorganised its termination of pregnancy service to avoid a recurrence of the failings we identified. We are satisfied that this is appropriate.

Organisation(s) we investigated

East and North Hertfordshire NHS Trust

Location

Hertfordshire

Region

East

Summary 695/December 2014

Practice did not manage new patient's pain medication prescription

Ms C's GP Practice did not follow guidance and established good practice on swift referral to help her get specialist medication. Ms C suffered uncertainty and ongoing pain.

What happened

Ms C used painkillers that she could only get through specialist prescribing. She had been managing her pain using these drugs for some time when she changed GP surgeries. The new GP Practice did not continue the prescription.

What we found

We partly upheld this complaint. The GP Practice decided correctly that Ms C's drug should not be prescribed in a primary care setting. However, it did not follow guidance from the General Medical Council, or established good practice, because it did not have an early discussion with Ms C. It did not refer her promptly for new specialist assessment while maintaining the prescription in the interim. We concluded that Ms C was left in pain and had been uncertain when or if she would be prescribed the painkillers again.

Putting it right

The GP Practice had already set up a new process to make sure it communicated effectively with patients like Ms C. It apologised further to Ms C for her pain and distress.

Organisation(s) we investigated

A GP practice

Location

West Midlands

Region

West Midlands

Summary 696/December 2014

Misdiagnosis prevented appropriate care

Mr P's daughter-in-law, Mrs L, complained that Mr P's diagnosis was unclear, his treatment was inadequate and communication from Trust staff was poor. The Trust acknowledged only minor communication failings and maintained that Mr P's care and treatment was appropriate.

What happened

Mr P was in his seventies when he first went into hospital in spring 2013 with shortness of breath and chest pain. He had a scan to investigate a possible diagnosis of cancer, and doctors thought that the scan results confirmed this. After a review at a multidisciplinary meeting, clinicians decided he did not have cancer but had a pulmonary embolism (a blood clot in the lung) and started Mr P on anticoagulant medication to thin his blood. This diagnosis was right.

Mr P went back into hospital in early summer 2013 with shortness of breath. Trust staff diagnosed pulmonary fibrosis (a chronic condition that causes scarring of the lung and breathlessness). This diagnosis was wrong, Mr P had a pulmonary embolism.

Mr P went back into hospital later that month and again the next month at the request of the community respiratory nurse and the community heart disease nurse. They were worried about Mr P's shortness of breath and low blood pressure. Mr P died in hospital just over a week after this admission.

What we found

The radiology adviser we consulted felt that the initial scan showed a pulmonary embolism: a large blood clot. He did not find anything to raise a strong suspicion of cancer.

It is established good practice for a medical team to check scans and form a diagnosis. There is no evidence that this happened before the scan was reviewed at a multidisciplinary team meeting. Even though pulmonary embolism was mentioned on Mr P's admission documentation and clearly showed on the scan, and there was no obvious sign of malignancy, staff accepted the initial reading of cancer without question. Mr P's pulmonary embolism was then untreated for seven days. There was no evidence that staff considered the cause of Mr P's symptoms, or planned how they would manage his care. This was a serious failing in his medical care.

Mr P's diagnosis of pulmonary fibrosis at his second hospital admission was apparently made on the basis of the scan taken earlier. There was no evidence to explain this diagnosis, which was incorrect. The diagnosis of pulmonary fibrosis was not only wrong, it also discouraged doctors from seeking other explanations for his ongoing and deteriorating symptoms. This was a serious failing in Mr P's medical care.

From this time until Mr P's death, there was no evidence that his pulmonary embolism, a blood clot on his lungs that persisted despite anticoagulation treatment, was adequately investigated, correctly diagnosed or properly managed. These were serious shortcomings by the Trust.

There were also failings in discharge decisions and the Trust's communication with Mr P's family. In addition, the community respiratory nurse got involved in Mr P's care very late.

Although there were serious failings in the standard of care and treatment the Trust gave Mr P, we thought it unlikely that, given his age and symptoms, different treatment would have altered the outcome. However, the substandard treatment given to Mr P meant that his family were not adequately supported during his illness and understandably lost confidence in his care.

There were shortcomings in how the Trust started a palliative care pathway for Mr P. This meant that Mr P and his family did not have the opportunity to come to terms with his condition and prepare for his death in the way he would have wanted. This compounded their grief.

Putting it right

The Trust agreed to apologise to Mrs L for the failings we found. It paid her £1,750 compensation and agreed to explain what it has done, or plans to do, to address its shortcomings.

Organisation(s) we investigated

County Durham and Darlington NHS Foundation Trust

Location

Darlington

Region

North East

Summary 697/December 2014

Hospital did not act on patient's written wishes

Mrs and Mr C complained that the Trust had not been aware of, and did not act on, Mrs C's advance directive (a document that set out her wishes about her treatment) and that communication with the family had been poor. They felt the Trust did not recognise the impact its actions had had on them, and its service improvements had not done enough to stop the mistakes happening again.

What happened

Mrs C had a history of mental illness. She had put together an advance directive for the Trust that explained what she wanted to happen when she was unwell.

The Trust did not act on Mrs C's wishes when she went into hospital because staff did not know about the advance directive. Mr and Mrs C said this delayed her getting the right treatment and distressed her family.

What we found

We partly upheld this complaint. The Trust did not know about, or act upon, the advance directive. It started appropriate treatment right away, however, so we did not find any delay in treatment that would have delayed Mrs C's recovery.

The failing led to Mr and Mrs C losing confidence in the Trust and this made them worried about what might happen in the future.

Putting it right

The Trust had already made improvements by putting all patient advance directives with the patient's records. It also gave staff additional training, used new care programme paperwork, reviewed advance directives and worked with its mental health legislation department to establish what information was needed to be added to electronic records. These improvements reassured us that the Trust had learnt from this complaint. We told Mr and Mrs C that we thought the Trust had done enough to stop these shortcomings happening again.

The Trust paid Mr and Mrs C£500 to compensate them for the distress caused and their worries about future care.

Organisation(s) we investigated

Humber NHS Foundation Trust

Location

Hull

Region

Yorkshire and the Humber

Summary 698/January 2015

Trust should have carried out further tests that might have shown man's cancer earlier

Mrs G, together with her son, complained about the care that her husband received from the Trust's pain management team when he developed new symptoms. They also said he should have had another MRI scan.

What happened

Mr G had a number of illnesses, for which different specialists were treating him. He had pain in his left leg which limited his ability to do any exercise so the Trust's pain team saw him.

Doctors gave him some medication and a physiotherapist gave him some exercises to do. An MRI scan showed some changes in his lower spine. Eight months later, his pain had improved and he was discharged from the care of the pain team.

Twenty-one months later, Mr G was again referred to the pain team, but this time his pain was on his right side and was more constant than before. He had also lost weight. A nurse discussed his symptoms with a doctor, who recommended some medication.

Over the next four months, Mr G had different medications but his pain did not improve. He was then seen by a doctor for pain in his shoulder and given further medication. Mr G's pain got worse and another doctor advised that no further tests were needed, but that the Trust could do a lumbar epidural (give pain relief directly into the space outside the sac of fluid that surrounds the spinal cord).

Mr G had this procedure but it did not improve his pain and he was no longer able to get out of bed. Six months after he was first seen with right-sided pain, Mr G went into hospital. His family complained that his notes appeared to recommend that Mr G was discharged before further tests were done. However, Mr G stayed in hospital, and following these and other tests, Trust staff diagnosed him with lung cancer. This had spread to his bones and he died about a month later.

Mrs G and her son said that if Mr G had had another MRI scan, his bone cancer might have been found earlier and he would not have experienced unnecessary pain and suffering. They also said that the Trust's poor handling of their complaint added to their distress. The family were promised an investigation, which never happened, and also a specific apology, which they never received.

What we found

We partly upheld this complaint. There were a number of occasions when a doctor should have seen Mr G, taken his full history and arranged for an MRI scan. This would have shown his cancer earlier, but it never happened. Despite the complexity of Mr G's condition, the Trust left his care to pain nurses to manage.

The way the Trust handled Mrs G and her son's complaint was poor and amounted to maladministration. The Trust gave conflicting information about the promised investigation that did not match the evidence we had seen. There was also no evidence of learning.

However, Mr G's pain management was reasonable and despite the family's concerns, pain nurses did not recommend that he was discharged from hospital before tests were completed; they were simply making sure that they would continue to see Mr G when he was eventually discharged.

Putting it right

The Trust apologised to Mrs G and her son and paid them £1,250 (to be shared between them) for the failings and the injustice caused to them. The Trust also prepared an action plan to describe how the organisation and individuals involved had learnt from this complaint.

Organisation(s) we investigated

James Paget University Hospitals NHS Foundation Trust

Location

Norfolk

Region

East

Summary 699/January 2015

Pharmacy gave mother wrong medicine for child

Mrs F was given the wrong medication for her young son. The medication was not suitable for children.

What happened

During a visit to hospital, Mrs F's son was prescribed medication for constipation. Mrs F visited the Pharmacy to pick up the prescription but staff gave her the wrong medication. Mrs F did not realise this error until she got home and read the accompanying leaflet. She consulted her local pharmacist, who told her that the medication the Pharmacy had given her was not suitable for children and could have had serious consequences for her son.

What we found

The Pharmacy dispensed incorrect medication. This was a failing in the service the Pharmacy provided, and could have had serious consequences.

Putting it right

After Mrs F complained to the Pharmacy, it acknowledged that it had dispensed the wrong medication and as a result, reviewed its dispensing practices. However, it did not offer a personal remedy for Mrs F, who told us that the experience had been upsetting for her.

Following our investigation, the Pharmacy apologised to Mrs F and paid her £100 in recognition of the distress caused. Mrs F was pleased with the outcome we achieved for her.

Organisation(s) we investigated

Sainsbury's Pharmacy

Location

Greater London

Region

London

Summary 700/January 2015

Trust put right its failings in care and treatment

Ms F complained about the care her late grandmother received, and about the fact that the family could not be with her when she died because staff had recorded only one contact number for the family.

What happened

Mrs W was in her nineties. She was admitted to hospital after she fell at home. A number of different doctors saw her and treated her for a urinary tract infection.

Just over two weeks later, Mrs W developed a clostridium difficile infection (inflammation of the large intestine) and Trust staff treated her for this. This was not successful, and after five days staff gave her a different treatment. Mrs W's condition deteriorated and staff tried to contact her family. However, there was no answer from Mrs W's son, the only telephone number that had been noted in the records by staff.

Staff contacted police, who went round to Mrs W's son address but discovered that he was away on holiday. Mrs W died during the night. The next morning staff found another telephone number and were able to get in touch with Mrs W's daughter.

What we found

We did not uphold this complaint.

Staff had made reasonable attempts to contact the family when Mrs W's condition deteriorated, although they could have contacted social services. But nurses had poorly completed the initial documentation and had not recorded two contact numbers for the family, as they should have done.

The assessment of Mrs W's needs when she was admitted was also inadequate; appropriate care plans were not put in place; and the risk assessment of her nutritional needs was wrong.

However, staff had completed other risk assessments and had monitored Mrs W as they should have. The care Mrs W received from doctors was also in accordance with established good practice.

Following our investigation the Trust had already apologised for the failings we had identified and had taken action to prevent similar failings from happening again. We did not therefore make any recommendations.

Organisation(s) we investigated

North Tees and Hartlepool NHS Foundation Trust

Location

Hartlepool

Region

North East

Summary 701/January 2015

The Trust did not properly assess Mr H's suitability to donate his kidney to his wife

Mr and Mrs H complained that Mr H was not retested in 2007 to see if he was a suitable live kidney donor. They were also unhappy with the way their complaint was handled.

What happened

Mrs H had chronic kidney disease. When she was diagnosed, Mr H expressed an interest in becoming a live kidney donor, and blood tests confirmed he was a match.

A consultant nephrologist (a kidney specialist) reviewed Mrs H in 2006. At this appointment, the consultant decided that Mr H would not be a suitable kidney donor because he had a mild congenital disease and a recent E. coli urinary tract infection. This decision was based purely on information given by Mr and Mrs H.

In 2007, a consultant transplant surgeon reviewed Mrs H. Following this appointment, she was added to the national transplant list and received a deceased donor kidney in 2009. Unfortunately, this kidney's function was not up to standard and doctors decided that she needed another transplant. Mr H was tested and found to be a suitable donor. Mrs H had a successful transplant with Mr H's kidney in 2012.

What we found

We partly upheld this complaint. There had been no evidence based assessment of Mr H's suitability as a kidney donor. Therefore, we considered that the consultant transplant surgeon should have explored this option in 2007 and documented his decision. He failed to follow good clinical practice when he did not do this.

Mr and Mrs H said that as a result of these failings, Mrs H had suffered ill health and this had affected their welfare. Mr H said that he had been on antidepressants because he was unable to donate a kidney to his wife.

There was an unreasonable delay in copies of medical records being sent to Mr and Mrs H when they requested these.

Putting it right

We concluded that, on the balance of probabilities, Mr H would have been found to be a suitable donor for his wife in 2007. However, we could not say that the failings identified led to the claimed injustice. This is because these resulted from the deceased kidney transplant being unsuccessful.

In our view there was a missed opportunity for Mr H to donate his kidney to his wife earlier. We concluded that this had caused uncertainty for Mr and Mrs H through not knowing whether the outcome could have been different had Mr H been retested in 2007.

During the course of our investigation, the Trust told us about the action it proposed to take as a result of the failings we identified. In our view, this was sufficient to resolve the primary concerns Mr and Mrs H had raised. The Trust apologised to Mr and Mrs H for the failings we found.

Organisation(s) we investigated

St George's Healthcare NHS Trust

Region

Greater London

Location

London

Summary 702/January 2015

Poor communication by doctors meant that a young woman's parents did not realise that she was going to die

Miss T's family complained that the care and treatment their daughter received for a brain tumour contributed to her death. They also said that poor communication by staff at the Trust added to their distress.

What happened

Miss T had an aggressive brain tumour. She had surgery at the Trust and doctors removed part of the tumour. Afterwards she suffered complications and clinicians carried out various procedures to try and resolve these. After several months of reasonable health, Miss T's condition worsened and she died after she went back into hospital. Her parents complained about the lack of communication from Miss T's consultant.

What we found

We partly upheld this complaint. The doctors at the Trust gave Miss T appropriate care and treatment but her tumour was relentless and incurable. Communication by the consultant and his colleagues was poor and this meant that Miss T's parents were distressed when they learnt that she was dying.

Putting it right

The Trust acknowledged and apologised for its failings in communication and for the distress this caused. It also prepared plans that demonstrated how the consultant had learnt from the complaint, and shared this with Miss T's family. The Trust also paid Miss T's parents £500 compensation.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 703/January 2015

Avoidable death of a man with learning disabilities after failings in care and treatment

Mrs H and Mrs M complained about the care and treatment of their brother, Mr P, in summer 2012.

What happened

Mr P had a learning disability and lived in a nursing home. He had several medical problems and needed special bowel care. In summer 2012, Mr P went into hospital with abdominal pains and vomiting. Nurses noted the special bowel care he needed as a result of his disability.

Tests showed Mr P had kidney impairment and a blocked bowel. Mr P's treatment plan included no food and drink, intravenous fluids, a tube to drain his stomach contents, a urinary catheter to measure his urine output and surgery only if he did not improve. Two days later, his condition started to improve and doctors decided to let him have drinks but to continue with intravenous fluids until he was also eating. Later that evening, his blood pressure dropped and his heart rate increased, and there was evidence that his heart was not pumping blood properly, so doctors gave him medication.

The next day doctors noted that Mr P was probably well enough to go home in a day's time. However, later that morning he again had low blood pressure and a raised heart rate. A nurse recorded an instruction to give Mr P intravenous fluids and encourage drinks. The records also show that doctors prescribed fluids, but no one gave him these.

The following morning, a doctor noted that Mr P was eating and drinking. Staff gave Mr P fluids and he was not vomiting. His blood pressure was slightly low but stable, and he passed urine. However, blood tests showed signs of a kidney problem. During the afternoon, Mr P's blood pressure dropped, and he vomited a large amount. A house officer told the nurse to call the senior house officer.

The nurse did so, and was told that the senior house officer would review Mr P, but there is no evidence of such a review. Nurses also asked the outreach team (a specialist team of senior clinicians) to visit and they gave advice, including to keep giving fluids. That night Mr P's blood pressure remained low and he had a fast heart rate.

At 11pm the on-call doctor, who was less senior than a senior house officer, reviewed Mr P. Among other things, he advised further fluids. Early the following morning, Mr P was very ill and he died a few hours later. The cause of death was multiorgan failure caused by intestinal obstruction.

What we found

Doctors and nurses did not communicate adequately with Mr P's family about his needs and treatment, and therefore did not consider his rights as a disabled person.

Doctors' initial care and treatment of Mr P was appropriate, but they did not act in line with applicable guidance or established good practice when his condition deteriorated. In particular, they failed to arrange daily blood tests to monitor Mr P's response to treatment to see whether his kidney function was returning to normal.

Although Trust staff gave Mr P fluids, overall he lost a large amount of fluid. Doctors should have made sure that he got enough fluids, and not just prescribed them. Doctors should have taken further action, including giving him drugs or transferring him to the intensive care unit to filter Mr P's blood, if necessary.

Nurses did not act in line with guidance or established good practice. They overlooked information about Mr P's bowel care needs and did not carry out an adequate assessment. They failed to recognise Mr P's needs as a person with a learning disability and their assessment and care plans were inadequate. When Mr P's condition deteriorated, nurses appropriately gave him fluids and contacted the senior house officer and the outreach team. However, they failed to make sure that senior medical staff saw Mr P in good time.

There was no indication that Mr P's condition was irreversible, and if he had received appropriate medical and nursing care, it was more likely than not that he would have lived. On the balance of probabilities, his death was avoidable.

Putting it right

Following our investigation, the Trust acknowledged and apologised for its failings and agreed to put together an action plan that showed learning from its mistakes so that they would not happen again. It also paid Mrs H and Mrs M £10,000 between them, to acknowledge the impact its failings had had on them.

Organisation(s) we investigated

The Dudley Group NHS Foundation Trust

Location

West Midlands

Region

West Midlands

Summary 704/January 2015

Trust's investigation into complaint failed to address key issues

When Miss T complained to the Trust about her mother's care, its response failed to address her key concerns and also the main incident she had complained about.

What happened

Mrs T, a diabetic, was admitted to hospital for amputation of her leg. Although she was initially well after the operation, a few days later she suffered a hypoglycaemic attack (caused by low blood sugar) and collapsed. She was transferred to the high dependency unit but died two days later.

Miss T complained to the Trust to highlight the fact that her sister had received a telephone call from a nurse saying that the night before her collapse, Mrs T had apparently argued about being allowed to test her blood glucose on the ward. Miss T said she was concerned her mother had been prevented from checking her blood glucose and that this had led to her collapse.

The Trust's response provided lots of information about Mrs T's admission but simply said there was no record of any argument.

Miss T complained to us and explained that she felt the Trust had missed the point of her complaint. She also highlighted other concerns about her mother's management.

What we found

We partly upheld this complaint. There was no evidence of any argument taking place. There was, however, clear evidence that Mrs T's blood glucose had been recorded regularly, including on the night before her collapse. Our clinical advisers told us that Mrs T's blood glucose was monitored appropriately and that the recordings would not have given any reason for concern.

However, the Trust had not properly identified or investigated Miss T's main concern. It had not identified or obtained statements from the nurses caring for Mrs T. Its response included some details about Mrs T's recorded blood glucose levels but did not explain when those readings were taken. These failings contributed to Miss T's distress about her mother's death and caused her further anxiety.

Putting it right

The Trust apologised to Miss T and agreed to review how it investigates complaints when individual staff are identified.

Organisation(s) we investigated

Medway NHS Foundation Trust

Location

Medway

Region

South East

Summary 705/January 2015

Inadequate pain relief for girl who had surgery for curvature of the spine

Ms P, a young adult, had surgery for curvature of the spine. Her mother, Mrs P, said staff did not give her enough pain relief. Records relating to this were unreliable, which meant that the Trust did not respond appropriately to Mrs P's complaint.

What happened

After Ms P's surgery to correct a curvature of her spine, she was in pain. Her mother complained to the Trust that during one particular night, nursing staff gave Ms P inadequate medication for pain relief. This, she said, had resulted in Ms P having a sleepless night in a state of pain and agitation, and in Mrs P losing confidence in the health service. The Trust investigated Mrs P's complaint but Mrs P was not satisfied with its response and complained to us.

What we found

Nurses did not assess and manage Ms P's pain properly and this caused her unnecessary suffering. The Trust's records relating to the administration of pain medication were not as reliable as they should have been, and this had a bearing on its handling of Mrs P's complaint. Mrs P was distressed by witnessing her daughter's suffering and by not getting a satisfactory response to her complaint.

Putting it right

The Trust apologised to Ms P and paid her and Mrs P £200 each. It also prepared an action plan which described what it has done or plans to do to avoid a recurrence of the failings identified in our report.

Organisation(s) we investigated

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 706/January 2015

Trust delayed giving cancer treatment

Mrs D complained about not getting treatment from the Trust after being diagnosed with cancer. She said that as a consequence of the Trust's failings, she suffered distress and was concerned her life expectancy had been affected.

What happened

Mrs D's GP referred her to the Trust because of rectal bleeding. A consultant found a mass in her rectum, and a scan showed that this was cancer. Three months later, the Trust had still to decide on the best course of treatment. Mrs D sought a second opinion from another trust and, within a few weeks, started immediate treatment for her cancer.

What we found

We partly upheld this complaint. As Mrs D had a complex medical history, delaying treatment was appropriate in order for the Trust to obtain specialist advice and to consider her suitability for surgery. However, as a consequence of administrative and medical failings, the Trust took too long to get the specialist advice.

Taking account of available research into the impact of delays in the treatment of rectal cancer, it is unlikely that the delays Mrs D experienced had a significant impact on her life expectancy. However, Mrs D suffered worry and anxiety as a consequence of the delays.

Putting it right

The Trust acknowledged its failings and apologised for the injustice Mrs D suffered as a consequence of these. It paid her compensation of £500, and produced an action plan to prevent the failings from happening again.

Organisation(s) we investigated

Medway NHS Foundation Trust

Location

Medway

Region

South East

Summary 707/January 2015

Social worker safeguarded woman in hospital although son was not happy about this

Mr H complained about the actions of a social worker and hospital staff while his late mother, Mrs A, was a patient in hospital in spring 2012. Mr H says this distressed him and Mrs A, and made her condition deteriorate.

What happened

In early 2012 Mrs A, who was in her nineties, was admitted to hospital. Mr H had enduring power of attorney (EPA) for Mrs A and gave ward staff a letter signed by her. The letter said Mrs A gave Mr H and his partner '*total and unrestricted authority to make all decisions on my behalf with regard to my welfare*'.

While she was in hospital Mrs A had a fall which Mr H thought could have been prevented. The next day Mr H says a solicitor visited his mother when she was unwell, that she signed documents and the solicitor received a cash payment.

A few days later, a social worker from the council visited Mrs A. Mrs A told the social worker she had not been consulted about the contents of the letter Mr H had given staff. She agreed to a safeguarding investigation.

Mr H went to visit Mrs A shortly after the social worker had visited but said his brother and the ward sister stopped him from going into the ward. He said he was told he could only visit Mrs A if his brother was present, and that his partner could not visit at all. Mr H said he repeatedly asked to speak to Mrs A but nursing staff refused.

Mr H also felt hospital staff refused to recognise he had EPA but accepted that his brother said he had 'power of attorney' when this was not the case.

Mr H met the social worker a week later. During the meeting, he said a relative knocked on the door and told the social worker Mrs A had asked to see Mr H. Mr H says the social worker spoke to senior nursing staff but he was still not allowed to enter the ward. Later, Mr H said he telephoned the ward to ask if he could visit, but was told he could not have '*unrestricted access*' to Mrs A.

Mr H said he took legal advice and a week later he went into the ward to Mrs A's bedside. He said staff did not try to stop him, and Mrs A asked why he had not been to visit for a week.

The next week, Mrs A was discharged to a care home. Later, Mr H obtained Mrs A's medical records. He said his contact details had been falsified, and that a 'do not attempt resuscitation' (DNAR) decision had been made and DNAR forms completed without Mrs A's authority or consulting him.

Mr H complained to us that hospital staff refused to recognise he had an EPA; stopped him from visiting Mrs A, but allowed a solicitor to visit her when she was unwell; and altered next of kin details in Mrs A's clinical records.

Mr H complained that the social worker raised a safeguarding alert and refused to read a summary of his concerns at the meeting with him.

He was also unhappy that Mrs A had a fall while she was in hospital.

What we found

We investigated this complaint jointly with the Local Government Ombudsman. We partly upheld this complaint. There was no fault on the part of the Trust in relation to who visited Mrs A as that was her decision. We found no fault in the DNAR decision, the recording of next of kin details and the EPA issue. The Trust knew Mr A had an EPA but it made no difference because EPAs do not relate to welfare or medical issues. In addition, Mrs A had mental capacity. All staff had done was document what family members said about the EPA. There was nothing to indicate staff either accepted or disputed the information provided. The evidence showed the Trust acted in accordance with Mrs A's wishes, which were to restrict Mr H's visits.

There was no fault in the council starting a safeguarding investigation. The records show there were concerns about a letter, and Mrs A gave consent for the investigation.

The social worker and Mr H had different recollections of the meeting in spring 2012. Mr H says he was still unable to see Mrs A after the meeting even though a relative had told the social worker that Mrs A wanted to see him. The social worker did not recall this. There was also no evidence that ward staff were aware of any request from Mrs A to see Mr H. As no information was recorded in the social work or health records about this, and in light of the time that had passed, we could not say exactly what happened during the meeting, or why Mr H was unable to see Mrs A that day. There was insufficient evidence to find fault here.

There was no evidence the Trust failed to prevent a foreseeable fall. However, we found fault in the Trust's actions after Mrs A's fall, as we were unable to see it had identified how the fall had happened or done anything to prevent further falls.

Putting it right

The Trust wrote to Mr H to acknowledge the lack of action it took after the fall and to apologise that because of this, it was unable to tell Mr H how Mrs A had fallen. It also explained to Mr H what action had been or would be taken to prevent this from happening again.

Organisation(s) we investigated

Walsall Healthcare NHS Trust

Walsall Council (investigated by the Local Government Ombudsman)

Location

West Midlands

Region

West Midlands

Summary 708/January 2015

GP and Trust's delay in diagnosing terminal cancer

Mr M complained about severe delays in sending his mother for tests. He felt that the delays meant that by the time his mother was diagnosed with cancer, she had only two weeks left to live. He also complained about a long delay in a visit by an out-of-hours GP when his mother was in pain.

What happened

Mrs T saw a number of GPs in the twelve months before she died. Some initial blood tests were normal but she continued to experience pain. The Practice eventually referred her to the Trust for investigation and tests, but there was a delay in carrying out the tests because staff did not read the request for them properly. This meant that the need for one of the tests was not spotted at first.

The GP Practice would not refer Mrs T for specialist cancer support until it had received the results of all the investigations, even though it was already clear she had the disease. Mrs T was then finally diagnosed with advanced cancer to her bones.

After the tests, Mrs T was in extreme pain and needed a GP to visit her at home outside normal surgery hours. The out-of-hours GP did not arrive for several hours.

Mrs T died two weeks after receiving her diagnosis.

What we found

The GP Practice missed opportunities to thoroughly explore Mrs T's symptoms; to refer her to a specialist when cancer was strongly suspected; and later to refer her for palliative support when she was struggling with pain. There were also administrative failings in how the GP Practice referred her to the Trust for investigations. This was because the referral was made by a nurse who was not authorised to do so (it should have been made by a GP), and the referral did not accurately reflect the clinical picture. Additionally, an appropriately qualified member of its staff did not keep Mrs T sufficiently updated about her referral.

There were also administrative failings by the Trust when it received the referral from the GP. This resulted in a delay in arranging some of Mrs T's tests. Also, when initial investigation results showed that Mrs T had cancer, the Trust missed an opportunity to speed up further investigations it had planned, and to recommend referring her to a specialist doctor.

Had it not been for the failings of the GP Practice and the Trust, an earlier diagnosis could have been made. However, because of the type of cancer Mrs T had, the outcome would not have been any different.

The out-of-hours GP service had already acknowledged that a fault with its computer software had told the assigned doctor that a home visit had already been made. This led to an unacceptable delay in Mrs T receiving a home visit, and left her in pain for several hours. However, the doctor could not have known the information on the computer was inaccurate.

Putting it right

The GP Practice and the Trust both acknowledged and apologised for the impact of their failings, and drew up plans which described how they would learn from Mrs T's experiences. The GP Practice and Trust both paid compensation (£700 and £400 respectively) to Mrs T's family in recognition of the distress caused to them.

The out-of-hours GP service apologised to Mr M for the unnecessary pain his mother suffered as a result of the delayed home visit. We noted that it took action to address the software problem as soon as it became aware of it.

Organisation(s) we investigated

A GP Practice

Bradford Teaching Hospitals NHS Foundation Trust

An out-of-hours GP service

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 709/January 2015

Serious failings in nursing care resulted in a missed opportunity to prevent a man's death

Miss D complained about the care provided to her father in 2010 and the way the Trust dealt with her complaint.

What happened

Miss D's father Mr F was admitted to hospital for a routine bladder operation. He developed an infection and died around a week later. Miss D complained to the Trust about the care her father received after his operation. It responded to say there had been problems with the nursing staffing levels at the time but it now had a new system to monitor staffing.

Miss D was not satisfied with this response and pursued her complaint. There were serious delays in responding to her. In a meeting with Miss D, the Trust acknowledged that the nursing care had been poor, leading to a missed opportunity to recognise the deterioration in her father's condition sooner. The Trust explained that it had made improvements to its care and complaint handling since.

Miss D brought her complaint to us because she was not satisfied that the Trust had done enough to put right the failings in the care or the complaint handling.

What we found

The Trust failed to monitor Mr F's condition and did not give him the nursing care he needed. It could have identified the deterioration in his condition sooner and treated his infection sooner. Because the infection was very severe, there was a 70% to 80% probability that Mr F would have died even if the care had been provided as it should have been. But an opportunity was missed to save his life.

The Trust also missed the opportunity to learn lessons from Miss D's complaint. However, it had made substantial improvements to both the care and the complaint handling since, which should prevent the same thing from happening to other people.

Putting it right

The Trust wrote to Miss D to acknowledge the failings we found and apologise for them. It also explained how it would make sure that it learnt lessons from complaints. The backlog of customer complaints has now been resolved and changes have been made to ensure the complaints process is better managed, and complaints are resolved faster

The Trust also paid her £1,500 in recognition of the effect of its failings on her.

Organisation(s) we investigated

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Location

Lincolnshire

Region

East Midlands

Summary 710/January 2015

GP Practice removed entire family from its list without warning

The Practice did not respond to Mr B's complaints, which dated back to 2011. When the Practice removed him from the list, his entire family were also removed.

What happened

Mr B complained about aspects of his care and treatment, but mainly about the Practice not giving him access to his blood results.

He also complained on behalf of his wife about her care after bariatric surgery, an operation to the stomach or digestive tract to help you lose weight.

The family said it was almost impossible to make appointments at the Practice, and raised concerns about the Practice manager being their GP's wife. They considered this added an element of bias to the GP's duty of care.

Mr B also complained about the fact that he, his wife, and their adult son and daughter were all removed from the Practice. He thought this was as a result of him having raised complaints.

What we found

We partly upheld this complaint. All the medical care and treatment provided to both Mr and Mrs B was reasonable.

There was nothing to suggest that the family struggled to make appointments, and we did not find any evidence of bias in the Practice's provision of care.

The Practice took reasonable steps and followed its policy in removing Mr B from the Practice list. This was not as a result of Mr B making a complaint, but it said Mr B had displayed aggressive behaviour.

The Practice said Mr and Mrs B's family always appeared unhappy with the care and service it provided. It said that it removed the family with great regret because the doctor/patient relationship had irrevocably broken down.

However, it was unreasonable and outside policy for the Practice to have removed the entire family from its list, as it had not first given each family member a written warning.

We saw that Mr B wrote complaints letters as far back as 2011 but the first time the Practice responded was via a local resolution meeting in winter 2013.

Putting it right

The Practice apologised to Mr B for the failure to respond to his earlier complaints and paid him £150 compensation. It also apologised to Mr B's wife and children for the impact of the unreasonable removal. The Practice also reviewed its removal policy and complaints policy and reminded staff of what was expected of them.

Organisation(s) we investigated

A GP practice

Location

Greater London

Region

London

Summary 711/January 2015

Trust acted reasonably in removing man's access to health promotion services

Mr S complained that the Trust removed his access to services because of his alleged bad behaviour, which he disputed.

What happened

Mr S had been a client at a confidential sexual health promotion service run by the Trust for several years. Recently, however, he had been repeatedly challenged by staff about his inappropriate language and behaviour towards other clients and staff. He was warned that continuing this behaviour would lead to the service being withdrawn from him. As a result of further inappropriate language and behaviour, he was sent a letter denying him routine access to the service.

Mr S said that he wanted the decision overturned as it was based on incorrect information.

What we found

We did not uphold this complaint. The Trust acted reasonably in accordance with its violence and abusive incidents policy in taking this decision.

Organisation(s) we investigated

Liverpool Community Health NHS Trust

Location

Merseyside

Region

North West

Summary 712/January 2015

Poor record keeping and poor communication with woman in labour who suffered complications after the birth

Mrs C had some poor experiences of care when she was in labour, and felt the complications she had after giving birth were a result of the Trust's actions and could have been avoided.

What happened

Mrs C went to the Trust's midwife-led delivery unit when she was in labour with her second child. She was concerned that her labour might progress very rapidly, as it had done with her first baby. She was admitted, but was then not checked for nearly three hours. Mrs C then needed to push. Her husband called for a midwife, who came to examine Mrs C but left the room to allow her time to undress. While the midwife was out of the room, the baby started to be born.

The baby was delivered safely but staff had trouble delivering the placenta, and transferred Mrs C to another hospital for surgery. There was a delay in reviewing her condition, and then she had to wait nearly two hours to be taken into theatre because of another obstetric emergency. During that time, her condition deteriorated, she haemorrhaged and her blood pressure dropped. Doctors successfully removed her placenta.

Mrs C needed blood transfusions after surgery and she also received counselling. She said there were communication problems and a midwife had made an inappropriate comment.

What we found

The Trust could not have prevented Mrs C from developing a retained placenta and the complications were not linked to the care she received. It had already acknowledged that the communication had not been as good as it should have been and that the midwife had made an inappropriate comment.

The midwife should not have left Mrs C unattended when she had urges to push. Mrs C was not monitored closely enough and the record-keeping was inadequate. The Trust had written an action plan to address the midwife's actions but this had not been followed through.

Mrs C had initially been stable enough to wait for the surgery but her condition deteriorated and there was a delay in a senior doctor reviewing her. Even if she had been reviewed sooner, she would not have had surgery more quickly, because of the time it would have taken for an on-call doctor to arrive and a second theatre to be opened.

Putting it right

The Trust agreed with our recommendations and it apologised to Mrs C for the failings we found and paid her £500 for the distress she experienced. The Trust also revisited the action plan to make sure all the issues we found relating to the midwife, as well as our criticisms about the failures in monitoring and record keeping, had been addressed. It also took steps to improve communication with expectant mothers on admission.

Organisation(s) we investigated

Mid Essex Hospital Services NHS Trust

Location

Essex

Region

East

Summary 713/January 2015

Nursing and medical staff did not escalate concerns to senior doctor

Mrs H complained of poor care while she was an inpatient. She said this resulted in her having a heart attack and stroke.

What happened

Mrs H was admitted to hospital with breathing problems. She said her condition deteriorated because of the poor care she received in the ward. She was sent to intensive care where clinicians diagnosed her with heart and lung disease.

Mrs H complained to the Trust but was unhappy with how it handled her complaint. She said she received contradictory information from the medical and nursing staff, and she was concerned that they did not seem to have learnt from any mistakes, or improved the service. She was unhappy that at the beginning of a meeting about her complaint, a member of staff said that if she wanted to escalate the complaint, the meeting would be a waste of time.

What we found

We partly upheld this complaint. There were failings in Mrs H's care and treatment. These included: a miscalculation of her vital signs; failure to take appropriate observations; failure by nursing staff to properly escalate concerns to the medical team; failure of the medical team to escalate concerns to a senior doctor, and poor record keeping. However, we could not say these failings led to a poorer outcome for Mrs H as she was already very ill.

These failings caused Mrs H and her daughter distress and uncertainty. They felt that if she had had better care on the ward, Mrs H would not have needed to go to intensive care. We agreed the failings left Mrs H uncertain about this, but we found she would have gone to intensive care even if concerns about her condition had been properly escalated to the senior physician.

There were also failings in complaint handling. These were: failure to take statements; poor record keeping; delays in providing responses; incomplete responses; inappropriate approach in a complaint meeting, and no evidence of improvements to the service.

Putting it right

The Trust apologised to Mrs H and paid her £600 compensation. It also paid her daughter £250 compensation and agreed to put plans in place to prevent the same mistakes happening again.

Organisation(s) we investigated

Lewisham and Greenwich NHS Trust

Location

Greater London

Region

London

Summary 714/January 2015

GP prescribed wrong medication to older woman at the end of her life

A GP at Mrs F's Practice prescribed her medication without taking into account her medical history or giving her adequate information. Mrs F's family were unhappy about another GP's attitude and behaviour.

What happened

Mrs F was diagnosed with rheumatic heart disease in 1976 and had fainting episodes that became more frequent in the 2000s.

In 2012, Mrs F had a home visit from a GP at the Practice, who prescribed medication that she took on the next two mornings. Following a reported '*funny turn*' (a faint), the same GP made a second home visit.

Mrs F's daughter, Ms J, contacted her mother's usual GP to query the medication, and several home visits and further contact followed. Mrs F died at home six days after the medication was prescribed. Her cause of death was listed as congestive cardiac failure in addition to rheumatic heart disease.

Ms J complained because she believed that the medication the first doctor prescribed led to her mother's '*agonising and rapid*' death. She was also unhappy about the delay in her mother receiving pain relief and antisickness medication.

She also complained about the usual GP's attitude and behaviour, including that he swore at family members.

Ms J passed her complaints to the NHS Area Team because she thought the Practice was taking too long to respond. She was unhappy about how the Area Team handled her complaint because of the length of time it took. She also felt the Area Team did not address all the issues she had raised, so she complained to us.

What we found

We partly upheld this complaint. While the medication the first doctor gave Mrs F could be used, the decision to prescribe it without taking into account her medical history or giving her adequate information was unreasonable. There was also a failing in that the medication was not stopped when it was thought to be causing Mrs F to faint.

We did not find this medication had any effect on Mrs F's subsequent death, but it is likely to have contributed in part to the episodes of fainting she experienced at that time, in turn causing Ms J distress.

We did not conclude that Mrs F's death was caused by any action taken by the Practice. The overall clinical care was reasonable and in line with established good practice.

We identified that Mrs F's usual GP could have given her morphine and antisickness medication sooner so she would have had earlier relief from the pain and nausea. We found the GP's acknowledgement and apologies to be reasonable, but recommended that the Practice took action to make sure that it changes doctors' future practice as a result.

Also, the usual GP's attitude and behaviour was not acceptable. As a result, Ms J and her family had been caused additional upset and distress. They lost trust in the GP at a time that is difficult for any family. We acknowledged that the GP identified his poor behaviour and apologised for this, and we found it reasonable that the Area Team took this issue up with the practitioner performance team, and will manage the GP's

future performance via the formal appraisal route. However, we were not satisfied that enough had been done to resolve the remaining upset and concern and set recommendations accordingly.

We also identified several failings in how the Area Team handled the complaint. The length of time it took to complete the complaint process was unreasonable, and the responses did not give sufficient weight to the lack of detail in the records about the prescription prescribed.

Putting it right

We made four recommendations to the Practice: a letter to Ms J to acknowledge the failings; an action plan to include staff training and information sharing on patient safety with regards to the prescription; training and reflection exercises, including a patient satisfaction survey for the named GP; and a review of medication prescription processes to avoid future delays.

We made two recommendations to the Area Team: that it sends a letter acknowledging the impact of the failing, and that it undertakes to draw up an action plan to review complaint handling processes to avoid future delays.

Organisation(s) we investigated

A GP Practice

North West London Area Team

Location

Greater London

Region

London

Summary 715/January 2015

Student physiotherapist stressed when bursary system changed

After a change in the way that NHS bursaries were calculated, a student found himself facing difficult financial circumstances when it was discovered he had been overpaid and the NHS Business Services Authority was to reduce his bursary to recover the overpayment. The reduction in his bursary payments contributed to his decision to withdraw from university and left him owing £1,800, which the NHS Business Services Authority later passed to a debt collection agency.

What happened

Mr A received a student bursary during the first year of his studies. At the beginning of his second year, he applied for a renewal of the bursary. At the same time, the NHS Business Services Authority was undergoing a major change in the way that it processed bursaries. This caused considerable delays in the processing of bursaries so it took the decision to simply award bursaries based on the previous year but with a disclaimer that it may be more or less than the correct amount, and any overpayments would have to be repaid in full. Mr A was not told of this arrangement.

During the university year, Mr A and the NHS Business Services Authority communicated several times about his bursary. Unfortunately the NHS Business Services Authority has destroyed all of its records.

The NHS Business Services Authority calculated Mr A's bursary the following spring and told him that he had been overpaid and it would recover the debt during the rest of term. This put Mr A under extreme financial pressure. He sent the NHS Business Services Authority additional evidence and it reduced the debt, but he still did not get enough money to pay his bills.

Mr A eventually dropped out of university because he could not afford to continue. The NHS Business Services Authority found out about this the following autumn and told Mr A that because he did not finish the year, he owed even more money (£1,800).

Mr A complained to the NHS Business Services Authority but his debt remained. He then approached us.

What we found

The NHS Business Services Authority's communication and handling of Mr A's bursary fell below the standards we would have expected to see. This resulted in considerable stress and inconvenience to Mr A, which the NHS Business Services Authority had not acknowledged.

However, we were unable to uphold Mr A's complaint that the NHS Business Services Authority was solely to blame for his withdrawal from university as we saw that Mr A could have done more and should have realised that his bursary would reduce at certain stages of the process.

Putting it right

To remedy the stress and inconvenience it had caused Mr A, NHS Business Services Authority paid him £1,000 compensation. (It reduced Mr A's existing debt by this amount.) It also apologised to him.

Organisation(s) we investigated

NHS Business Services Authority (Student Bursaries)

Summary 716/January 2015

Woman left with ongoing abdominal pain following hip replacement surgery

After Mrs B had her second hip replacement she developed ongoing severe abdominal pain. Three years later, this has not been resolved.

What happened

Mrs B's right hip was successfully replaced privately. Six months later, as an NHS patient at the same hospital, she had her left hip replaced. After the second surgery, Mrs B developed significant abdominal pain. Doctors are unable to diagnose the cause of her pain, or resolve it.

What we found

We did not uphold this complaint.

The care given during the surgery was in line with recognised quality standards and established good practice, and there were no failings. The various clinicians since involved in Mrs B's care have taken all reasonable actions to try to resolve her ongoing problems.

Organisation(s) we investigated

Nuffield Health Plymouth Hospital

Plymouth Hospitals NHS Trust

Location

Plymouth

Region

South West

Summary 717/January 2015

Trust failed to give reasonable care in relation to a do not resuscitate order

When Ms A's father, Mr J, became very ill, the Trust did not talk to his family before it put a 'do not resuscitate' order on his file. The nurses also did not prepare Ms A's father's body suitably before the family went in to say their goodbyes.

What happened

Mr J was in his nineties when he was admitted to the Trust following a fall at home. He had a complex medical history, including a previous quadruple heart bypass, a pacemaker, and diabetes. He had been generally unwell for a few days, with a reduced appetite, before he fell. When he went into hospital, he was found to have low blood sugar and poor kidney function. He was diagnosed with haemophilus influenza (a serious bacterial infection that can lead to pneumonia) and staff gave him antibiotics. Mr J remained unwell and died a few days later.

What we found

We partly upheld this complaint. There were failings in the care given by the Trust in relation to both the instigation of the 'do not resuscitate' order, and the nursing care after Mr J's death. These were not in line with recognised quality standards and established good practice.

There were no failings in relation to the rest of the clinical and nursing care given by the Trust, and general communication with Ms A was reasonable.

Putting it right

The Trust apologised to Ms A and paid her £500 compensation. It also put a plan in place to make sure the issues we identified did not happen again.

Organisation(s) we investigated

Royal Free London NHS Foundation Trust

Location

Greater London

Region

London

Summary 718/January 2015

Ongoing problems caused by heel injury and not by treatment at Trusts

Mrs M complained that two Trusts failed to treat her properly for a fracture of her left foot. She said that this led to a prolonged recovery from her injury and caused her undue pain.

What happened

Mrs M fell down some stairs in summer 2011. She was away from home at the time and was taken by ambulance to Leicester Royal Infirmary (the Leicester Trust). A doctor from trauma and orthopaedics saw her and diagnosed a broken heel. Staff told Mrs M that she would need to stay in Leicester for initial treatment, but her treatment would then be with her local hospital in Lincoln, which was part of the Lincolnshire Trust.

The immediate priority for treatment was to reduce the swelling. Clinicians expected this to take two to three days. Mrs M said she was told the swelling would be reduced by keeping her foot elevated and placing it in an iceboot, a boot filled with ice water. She was told she would have a cast on for around six to eight weeks and then she would be allowed to walk on her foot.

Mrs M expressed concern that Leicester Trust staff did not give her an iceboot and she also had to ask for a pillow to keep her foot elevated. On the fifth day of her admission, staff put her foot in a cast and discharged her.

Following discharge, Mrs M said, she said she could feel her foot '*hitting the cast*' and she had severe pain. She phoned an NHS helpline and was advised to go to a hospital.

Soon after, Mrs M went to Lincoln County Hospital, part of the Lincolnshire Trust, where staff removed her cast in A&E. They asked her to go back the next week, when she was admitted to the Lincolnshire Trust.

Mrs M again felt she did not receive appropriate treatment as there was no elevation for her foot and she felt the ice pack available to her was too small. She also said she fell during the night on the ward whilst trying to transfer herself from the wheelchair to the toilet. She saw a doctor the next day and was discharged later the same day.

Following her discharge from the Lincolnshire Trust's outpatient department in early autumn 2011, Mrs M said she was referred for many appointments by her GP for scans and further treatments. She was left with pain, mobility and other long-term health problems. She said that because she has had to walk with her weight on her right foot, she has lost muscle in her left leg, has problems with both knees and has suffered spinal problems. She is now having a special boot fitted to try to keep her foot straight to improve her mobility. She felt that this could have been avoided had she been properly cared for by both Trusts.

Mrs M complained to both Trusts during 2012 and 2013. Although the Trusts offered apologies for some aspects of her care, they offered no acknowledgement that the problems she continued to experience were related to the way the Trusts had treated her shortly after the injury. As she was unhappy with the final responses, Mrs M brought her concerns to us.

What we found

We did not uphold this complaint. Although the Leicestershire Trust apologised that at the time of her admission there was no ice available for her, there were insufficient frames to help her walk and that the person applying the plaster cast was working alone, our review of the clinical records shows that the Trust followed established good practice in treating Mrs M and that there were no serious failings in her care.

The treatment given to Mrs M by the Lincolnshire Trust was also in line with established good practice and there were no failings.

The choice of conservative (that is, non-surgical) treatment for Mrs M was designed to relieve pain, reduce swelling, make sure the fracture healed with the heel properly aligned and safely mobilise and rehabilitate Mrs M. Whilst the availability of ice or equipment may help reduce swelling, it is not essential and does not affect the long-term outcome.

Mrs M has unfortunately continued to suffer severe pain. Her joint pain and chronic regional pain syndrome are both a consequence of the injury, not her treatment. Her treatment was in line with established good practice and her experience, although very unfortunate, is a consequence of this type of injury and is not an outcome of her treatment by either Trust.

Organisation(s) we investigated

University Hospitals of Leicester NHS Trust

United Lincolnshire Hospitals NHS Trust

Location

Leicestershire and Lincolnshire

Region

East Midlands

Summary 719/January 2015

Trust appropriately remedied failings in midwifery care

Ms T complained to the Trust about the lack of midwifery care she experienced following her discharge from hospital after she gave birth to her son. She felt that the lack of support affected her son's and her own health. Ms T was also unhappy about the Trust's complaint handling.

What happened

In autumn 2013 Ms T gave birth to her son in hospital and was discharged. Trust staff told Ms T that a community-based midwife would visit her the next day but this visit did not happen. Ms T telephoned the hospital and a midwife saw her the following day. Another visit was scheduled for two days later.

Ms T telephoned the hospital because the midwife did not visit her as arranged. The midwife then visited later the same day. Ms T's son was admitted to hospital for tests and further investigations because he had lost some weight.

A week later, Ms T attended hospital and reported that she had passed a piece of placenta that her body had retained after labour. A doctor examined her and she was discharged after a review that found there was no evidence of a retained placenta.

When Ms T complained to the Trust, it maintained that staff had given Ms T and her son an appropriate standard of care and treatment. However, it acknowledged that it had not adhered to its own policy in relation to the timing of the midwifery visits. The Trust apologised and also told Ms T about the steps it had taken to address these failings.

Ms T remained unhappy and came to us.

What we found

We did not uphold this complaint. After carefully considering all the evidence, we were satisfied that the Trust had reasonably addressed all of Ms T's concerns. The Trust had given her appropriate apologies and had also demonstrated that it had drawn organisational learning from her complaint.

Organisation(s) we investigated

Blackpool Teaching Hospitals NHS Foundation Trust

Location

Blackpool

Region

North West

Summary 720/January 2015

Trust gave patient confusing discharge information that led to early removal of protective plaster

Mrs E complained that the Trust's nursing staff incorrectly told her to have a protective plaster removed one week after she had an operation.

What happened

In the summer of 2013, Mrs E went into hospital to have an operation to remove a small bone in her hand. After the operation, the discharging nurse gave Mrs E handwritten aftercare advice to make an appointment with her GP and have the wound reviewed in one week. Mrs E subsequently went to her GP and the protective plaster was removed. When Mrs E returned to the hospital the following week, the therapist queried why the plaster had been removed and reapplied it.

Mrs E's husband complained to the Trust on behalf of his wife that removing the protective plaster early, in line with the discharge advice the Trust gave her, meant his wife suffered pain that could have been avoided.

The Trust apologised and paid Mrs E compensation of £250 for the pain and distress caused by the inaccurate discharge information and lack of communication from the patient experience team. Mrs E was dissatisfied with this response and came to us.

What we found

We partly upheld this complaint. Although the operation was carried out to Mrs E's satisfaction, it was clear that the discharge summary form template was ambiguous. The discharge nurse then made things worse when she gave Mrs E unclear and confusing written advice that led to the protective plaster being removed eight days early. Although this did not affect the final outcome of this operation, it meant that Mrs E had eight days of additional pain. We felt that the £250 compensation paid by the Trust was reasonable in these circumstances.

Putting it right

The Trust told Mrs E about the service improvements it had made in light of her complaint.

Organisation(s) we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 721/January 2015

Trust failed to start a patient's dental treatment within the 18-week national standard

Mr A developed a tooth abscess. His dentist was unable to treat this and referred Mr A to the Trust for specialist treatment.

What happened

Following the referral to the Trust, Mr A waited for 41 weeks before he saw a Trust clinician who could offer the specialist treatment. The Trust apologised for the long wait but said that dental services did not come under the national standard time limit, which is 18 weeks from referral to treatment.

While he waited for the dental treatment from the Trust, Mr A continued to suffer pain and tooth infections. He was prescribed antibiotics and painkillers, including codeine, to try to control this.

What we found

We took advice from a dental adviser and a physician adviser. The Trust's endodontic service (a dental service concerned with specific parts of a tooth) was consultant led. Therefore, Mr A should have been seen within 18 weeks of referral. This did not happen. The Trust did not get it right and this was service failure.

Because of the Trust's failure to begin treatment within 18 weeks, Mr A continued to suffer further infections of the affected tooth. He took codeine on a regular basis to relieve the pain. Mr A suffered from constipation, a common side effect of taking codeine. His constipation was severe and he went on to develop haemorrhoids and anal fissures, which caused him great distress. This was an injustice to him.

Putting it right

The Trust wrote to Mr A to acknowledge the service failure we found and apologised for the effect it had on him. It also paid him £2,000 in recognition of the injustice caused to him.

The Trust agreed to prepare an action plan describing what it had done, or planned to do, to prevent this failing happening again.

Organisation(s) we investigated

Central London Community Healthcare NHS Trust

Location

Greater London

Region

London

Summary 722/January 2015

Failings in hospital discharge process led to development of serious pressure ulcer

Mrs Y complained (on behalf of her mother-in-law) that her father-in-law should not have been discharged from hospital and that the pain from the pressure ulcer he developed ultimately caused his heart failure and death.

What happened

Mr Y was admitted to hospital in early 2013. Staff considered that he was medically fit for discharge a month later. His wife was certain she would be unable to care for him at home and so refused the proposed care package, hoping this would delay the discharge. However, Mr Y was still discharged and spent up to seven hours in the discharge lounge before he was taken home by ambulance. He was unable to walk into his house unaided and then slept in a chair at home for the next 36 hours. After Mrs Y spoke to her GP, Mr Y went back to hospital, where staff found that he had developed a large pressure ulcer at the base of his spine. Mr Y stayed in hospital for another six weeks before he was discharged to a nursing home. Sadly he died three weeks later. Mrs Y said a nurse told her that the pain from her husband's pressure ulcer caused his heart failure.

Mr Y's wife complained but was unhappy about the Trust's first response. After her daughter-in-law met the Trust, it arranged for a review of Mr Y's care. The review identified several flaws in the Trust's first response and concluded that staff should not have discharged Mr Y without first investigating his wife's concerns. The Trust apologised to Mrs Y for letting her and her husband down by '*inappropriately*' discharging him and for mistakes in its initial response.

Mrs Y remained unhappy and asked her daughter-in-law to bring the complaint to us.

What we found

We partly upheld this complaint. We agreed with the Trust that it was inappropriate to discharge Mr Y. We also agreed there was no evidence he received any care during his time in the discharge lounge. We were satisfied there was no indication he needed pressure area care before his discharge. However, on balance, the inappropriate discharge was a significant factor in the development of Mr Y's pressure ulcer because Mr and Mrs Y had no support at home so Mr Y was not moved for 36 hours. There was a slight delay in giving Mr Y appropriate pressure care when he was readmitted but otherwise the pressure care he received throughout the rest of his admission was reasonable.

The nursing and medical advice we received clearly told us that the pain from Mr Y's pressure ulcer would not have been a significant factor in his heart failure.

Putting it right

The Trust gave Mrs Y a further apology for the consequences her husband experienced as a result of the inappropriate discharge decision. It also paid her £750 compensation.

The Trust agreed to create an action plan to identify and address any learning from this complaint to try and prevent similar circumstances occurring again.

Organisation(s) we investigated

Nottingham University Hospitals NHS Trust

Location

Nottingham

Region

East Midlands

Summary 723/January 2015

Trust failed to give treatment in good time

A patient experienced a ten-month delay before treatment was started.

What happened

Miss Y was referred to the Trust's young adult hip preserving service with hip pain. Staff told Miss Y there could be a delay of up to six months before she was treated, but in fact it was ten months before her treatment started because of a lack of available clinicians. During this time, Miss Y's condition deteriorated and she was also unable to continue with the sports coaching that was part of her career.

What we found

The Trust apologised to Miss Y for the delays in treatment. However, while the Trust was aware of the cause of most of the delays, it made no provision for alternative sources of treatment. Under the NHS Constitution, patients have a legal right to start their NHS consultant-led treatment within 18 weeks of referral. The Trust was aware of this right and failed to take action. It also wrongly said that it could not consider requests for compensation under the NHS complaints procedure and suggested that Miss Y take legal advice if she wished to pursue this.

Putting it right

The Trust acknowledged that there had been a systemic failure on its part and paid Miss Y compensation of £500 for the distress its failing caused her.

Organisation(s) we investigated

University Hospitals Coventry and Warwickshire NHS Trust

Location

West Midlands

Region

West Midlands

Summary 724/January 2015

Trust's poor communication led to a distressing labour and delivery

Ms R's second labour and delivery were problematic and distressing because the Trust did not communicate well or give adequate pain relief. Ms R did not get appropriate pain relief when she later developed a uterine infection.

What happened

Ms R complained about the events around the birth of her second child at the Trust in 2013. A week after the birth, she was readmitted to the Trust with postnatal bleeding and infection caused by some of her placenta remaining in her uterus.

When Ms R went to the Trust in labour, staff assessed her and found she was in established labour but her cervix, which dilates to 10cm during labour, was only 2cm dilated. Staff monitored Ms R but delayed giving her pain medication, although she was in significant pain and had told a midwife that something was wrong.

Trust staff failed to assess the exact position of Ms R's baby at an early stage. Because she had only dilated a small amount, staff were concerned that her previous caesarean scar might rupture, so prepared her for a caesarean section. But, at the last minute, Ms R dilated and was able to have her baby delivered vaginally with forceps.

One week later, when she was at home, Ms R started sweating and shaking and had a foul-smelling blood discharge. She went to a routine appointment for the baby and told midwives about this. They did not take her temperature. Two days later, Ms R had heavy vaginal blood loss and went to the Trust's hospital, where she was unreasonably asked to wait in reception although she visibly needed urgent attention. Ms R suffered from retained placental products (part of the placenta had not been delivered during or after the birth). Trust staff manually removed these.

What we found

We partly upheld this complaint. It was evident that Ms R found her birthing experience very distressing. Had appropriate communication, support and pain relief been given, and if staff had identified the baby's position when Ms R arrived at hospital, her experience could have been quite different. We acknowledged that the Trust had taken some action in light of these shortcomings; however, we set out recommendations for further action.

There was no evidence to suggest that the clinical decisions about the delivery or the delivery itself were inappropriate, and the delivery by forceps was well-managed and followed national guidance.

While it was unfortunate that Ms R experienced a uterine infection after the delivery, there was no evidence to suggest that the care at delivery caused this. We identified that it might have been possible to intervene and treat the infection earlier if midwives had taken Ms R's temperature and found it to be abnormal. But we do not know that her temperature would have been raised, and additionally she did not present with symptoms that suggested a uterine infection. We therefore could not conclude that there was any remaining injustice but we made a recommendation in light of the missed opportunity to identify Ms R's uterine infection.

Although it was not appropriate that Ms R was asked to wait when she was actively bleeding on arrival at the Trust, records indicate that staff managed her haemorrhage and infection appropriately. Staff should have offered Ms R pain relief during the examination and the subsequent procedure to make this more tolerable. We noted that the community midwives recognised how distressed Ms R was and offered support. A postnatal debriefing occurred, both of which were reasonable steps.

Putting it right

The Trust wrote to Ms R acknowledging and apologising for the failings identified, and paid her £500 to acknowledge the pain and distress caused as a result of the missed opportunity to provide adequate pain relief, support and communication during the labour and delivery period. The Trust also prepared action plans to describe what it has done and/or plans to do to reduce the likelihood of similar shortcomings in future.

Organisation(s) we investigated

Medway NHS Foundation Trust

Location

Medway

Region

South East

Summary 725/January 2015

Trust failed to identify signs of infection in blood test

Mrs U complained that her mother, Mrs T, was not given adequate treatment when she was admitted to hospital with an infection and she was discharged despite having had a blood test that showed infection.

What happened

Mrs T was admitted to hospital with hip pain. Clinicians decided that it was appropriate to discharge her after about a week because they considered her to be clinically fit. After Mrs T's discharge, her final blood test result arrived at the ward. The result indicated signs of infection. Mrs T returned to hospital about a week later and was diagnosed with sepsis. She was treated, but deteriorated. She died a few days after readmission.

What we found

The Trust reasonably prepared Mrs T for discharge. However, in light of the significant results that arrived after Mrs T had left hospital, more should have been done to follow up her care after discharge. We believe this would have led to further treatment. We did not consider that it was likely that further treatment would have prevented Mrs T's death, but we felt that her family lost the opportunity to be reassured about this.

Putting it right

The Trust agreed to apologise to Mrs T's family, complete a clinical review to identify how to prevent anything similar happening again and give an update on a review it has started into how staff check blood tests after a patient's discharge.

Organisation(s) we investigated

Sandwell and West Birmingham Hospitals NHS Trust

Location

West Midlands

Region

West Midlands

Summary 726/January 2015

GP Practice's failure to repeat blood tests resulted in delayed diagnosis of a thyroid condition

Mr and Mrs R complained that the GP Practice missed opportunities to diagnose and treat Mrs R's low thyroid condition.

What happened

Mrs R went to the GP Practice for advice as she and her husband were trying for a baby but had been unable to conceive. A GP arranged for blood tests to be carried out. These showed that Mrs R's thyroid-stimulating hormone level was high and should be tested again in three months. The Practice did not arrange a repeat blood test. Mrs R attended the GP Practice on several occasions after this about related issues but a repeat blood test was not carried out.

Mrs R later went on to conceive but suffered two miscarriages. She was diagnosed with hypothyroidism, an underactive thyroid gland, two years later.

What we found

In line with good clinical practice, it was the GPs' responsibility to ensure that the appropriate investigations were carried out when the blood test showed that Mrs R's thyroid stimulating hormone level was raised. There was no evidence that Practice staff made arrangements for repeat blood tests at the initial consultation, and at subsequent appointments the GPs did not take action to address this.

We concluded that the lack of action by the GPs had delayed Mrs R's diagnosis of hypothyroidism by two years. However, whilst hypothyroidism can cause low fertility and increases the risk of miscarriage, there are many other factors that can contribute. Therefore, we could not say that the failure to diagnose and treat hypothyroidism caused Mrs R's low fertility or resulted in her miscarrying.

Putting it right

We decided that it was likely that Mrs R was put at increased risk of low fertility and miscarriage because of the failings by the GP Practice. The GP Practice had closed before Mr and Mrs R complained so NHS England took responsibility for dealing with the complaint. NHS England paid Mr and Mrs R £750.

Organisation(s) we investigated

Leicestershire and Lincolnshire Area Team

Location

Leicestershire

Region

East Midlands

Summary 727/January 2015

Trust did not remedy failings found in maternity care

Mrs C complained about the pre and post-natal care she received at the Trust, including delay in finding her a bed after she had given birth. Mrs C said that the failings she experienced contributed to her being unable to establish breast feeding. She also said she had suffered anxiety. She sought a refund of her costs and compensation for distress caused.

What happened

Mrs C went to hospital after her waters had broken and she was in labour. She gave birth late in the evening of the same day. There was a delay of several hours before she was transferred to a bed early the next morning. Mrs C stayed in hospital and a paediatrician reviewed her the next day in the late afternoon. Mrs C was then sent home.

What we found

We partly upheld this complaint. When Mrs C went to the hospital, staff should have offered her a vaginal examination earlier than they did. There was a delay in staff giving Mrs C a bed after she had given birth and there was a delay in her discharge. In addition, the Trust had not properly considered whether a financial remedy was due.

We did not consider that the failings had contributed to Mrs C not being able to establish breast feeding. However, we decided that, taken as a whole, the failings we identified had caused Mrs C anxiety and distress.

Putting it right

The Trust had already taken action to address the failings we identified when staff left Mrs C in a chair after she had given birth. It had discussed the issue at staff meetings and had put up posters to raise awareness. We were satisfied that the action was adequate. Therefore, we focused on remedying the injustice to Mrs C. At our recommendation, the Trust refunded the car parking costs associated with the delayed discharge (£22) and paid £100 compensation for the distress caused.

Organisation(s) we investigated

Mid Staffordshire NHS Foundation Trust

Location

Staffordshire

Region

West Midlands

Summary 728/January 2015

GP Practice unfairly removed entire family from its list

Miss G complained that she and her daughter had been removed from the GP Practice's patient list because of missed appointments. Her partner Mr W complained that although he had not missed any appointments, he too was removed.

What happened

In spring 2014, the Practice wrote to Miss G informing her that she was being removed from its list after she had missed three appointments in the previous 12 months. The Practice said that it had sent Miss G a warning after she had missed the first two (consecutive) appointments. Mr W also received a letter saying that he was being removed from the list. Miss G contacted the Practice to explain why the appointments had been missed and said it had not been made clear that she had previously missed two appointments. She asked the Practice to reconsider but it stood by its decision, even when her employers tried to intervene on her behalf.

What we found

We partly upheld this complaint. When it removed Miss G from its list, the Practice had followed its attendance policy and it had correctly issued her with a warning before it removed her.

However, the decision to remove Mr W was unreasonable. He had not missed any appointments and we did not see any other reason for his removal. It was unfair that he had effectively been removed simply because of his association with Miss G, and this was not consistent with established guidance.

Putting it right

The Practice apologised to Mr W and reviewed its removal policy to make sure that it is consistent with established guidance.

Organisation(s) we investigated

A GP practice

Location

Kent

Region

South East

Summary 729/January 2015

Trust could have offered better support after eye surgery

Miss V had cataract surgery. She complained about later eye problems that she felt were caused by the surgery.

What happened

Miss V had cataract surgery on one eye. She went on to develop problems with her eyes that she believed were a result of the surgery or the aftercare.

When Miss V went back to the Trust, it initially advised her to be patient. It then told her to see her GP. Miss V has since developed cosmetic problems with bags under her eyes. She felt that better care would have avoided this.

What we found

We did not find that the difficulties Miss V experienced were linked to any failings in her cataract surgery, or aftercare. However, the information the Trust gave her before surgery could have been more explicit about the possible side effects, and the Trust should have given Miss V better aftercare rather than directing her to her GP.

There was a missed opportunity to give Miss V more information before her surgery. However, when we looked at the information the Trust gave her, we decided that Miss V would have had the procedure if she had had more information.

Miss V lost the opportunity to feel more supported when she tried to approach the Trust for advice.

Putting it right

The Trust agreed to update its preoperative cataract information to ensure it presents all common side effects of cataract surgery, and amend its postoperative advice for patients. We also said it should improve record keeping when patients report problems.

Organisation(s) we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 730/January 2015

Ambulance Trust correctly assessed initial 999 call, but there were shortcomings in second call

When Mr N's housemate called 999 on his behalf, he was referred for a clinical telephone assessment instead of an ambulance being immediately sent. Mr N was not retriaged during the second 999 call.

What happened

Mr N's housemate called 999 on his behalf and reported that he was experiencing abdominal pain and vomiting. Using a software package, the emergency medical despatcher decided Mr N was a '*C4 priority*', so no ambulance was necessary. The despatch system played a recorded message explaining that an ambulance might not be sent immediately and that a clinical adviser might call back to assess Mr N further so the correct help or treatment could be arranged. The despatcher made a referral to the Trust's clinical centre for a telephone assessment.

Before the telephone assessment could be done, Mr N's flatmate called 999 again. The despatcher asked if there had been any change in his condition, and Mr N's flatmate said that he was perspiring. The despatcher said that an ambulance had not been sent as one was not available for him and the ambulance service was very busy. Mr N's housemate said they would go to hospital by car. Mr N later complained that an ambulance had not been sent.

What we found

We did not uphold this complaint because the Trust had already put things right. The Trust's use of the software that allocated the priority, meaning that an ambulance was not immediately sent, was in line with relevant guidelines and with established good practice. The Trust should have retriaged Mr N when his flatmate said there had been a change in his condition. However, we did not consider this had any detrimental impact on Mr N. The second despatcher's comments about the level of activity that night amounted to a shortcoming, but we did not consider that this amounted to service failure.

Organisation(s) we investigated

London Ambulance Service NHS Trust

Location

Greater London

Region

London

Summary 731/January 2015

Trust did not tell woman about all her treatment options

Ms H had fibroids and a growth on an ovary. The Trust did not provide all the necessary investigations and information, which meant that an early opportunity for treatment was lost.

What happened

When Ms H had a scan at the Trust, it showed a fibroid, a non-cancerous tumour that grows in or around the womb, and a growth on an ovary. Clinical staff discussed possible treatments with Ms H but did not perform any more tests or offer non-surgical treatment. Ms H did not want surgery. The Trust did not discuss her plans for having children with her.

After Ms H moved to a different area, another trust diagnosed different causes for Ms H's symptoms and she had treatment.

What we found

The Trust should have arranged another scan and follow up for Ms H's ovarian problem. With regard to her fibroids, it should have discussed her plans for having children as well as offering other treatment options. The Trust should have written to her more quickly after her consultation. These failings meant that there was a lost chance to address Ms H's symptoms at the earliest opportunity. This led to her suffering health problems longer than necessary.

Putting it right

The Trust apologised for the impact these failings had had on Ms H and paid her £350 compensation in recognition of the injustice she experienced as a result.

Organisation(s) we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 732/January 2015

A surgeon did not tell a patient about what happened during an operation

During Mr T's colon operation, his surgeon accidentally nicked Mr T's spleen, causing bleeding. The surgeon did not tell Mr T about this, and two weeks later his spleen ruptured and he had to have an operation to remove it.

What happened

When the surgeon nicked Mr T's spleen, he was able to stop the bleeding and the operation proceeded successfully. However, the surgeon considered the injury to be minor and did not tell Mr T what had happened because he did not think that it would lead to any complications.

Trust staff advised Mr T to rest for two weeks after the operation, and said that he could then go back to his normal activities. Four days after Mr T returned to his normal level of activity, he was admitted to the hospital as an emergency with severe abdominal pain. Investigations showed that his spleen had ruptured and was bleeding into his abdomen. Mr T had an emergency operation, during which his spleen was removed.

When Mr T complained to the hospital, he said that he was not complaining about the fact that the injury to his spleen happened during the initial operation, but that he was not told about it. He said that, had he known about the injury, he would have taken more care during his postoperative recovery period, and that his spleen may then not have ruptured.

What we found

We partly upheld this complaint. Injuries to the spleen are a known risk that can happen in up to 8% of operations on the colon, so the fact that the injury occurred was not a failing in itself. The General Medical Council's relevant guidelines, *Good Medical Practice* and *Good Surgical Practice*, both state that doctors and surgeons must tell patients about any complications or harm that happen during treatment, and act to put them right. This includes advising patients appropriately about their postoperative care.

The surgeon took action to put things right during the operation by stopping the spleen bleeding. However, he should have told Mr T about what had happened to his spleen during the operation. Trust staff should have given Mr T appropriate advice about his postoperative care, which in spleen injuries is to rest and refrain from normal activities for six weeks, and to avoid taking part in contact sports for four to six months. There were failings in communication between the surgeon and Mr T, in that Mr T was not told about the injury to his spleen or given appropriate aftercare advice.

Mr T felt that if he had been told about the injury and given appropriate aftercare advice, which he said he would have followed, his spleen would not have ruptured and he would not have needed the second operation to have it removed. Mr T was not given the chance to reduce the risk of his spleen rupturing because he was not told about the injury or given appropriate aftercare advice. Refraining from normal physical activities for six weeks after the operation would have reduced the risk of further bleeding in the spleen. However, we were not able to say that the spleen would definitely not have ruptured if the failing in communication had not occurred. For this reason, we partly upheld the complaint.

Putting it right

The Trust had already taken action to prevent the situation from happening again after responding to Mr T's complaint. It said it now asked all surgeons to discuss any complications that arise during surgery with the patient at the time that they occur, and to report any such complications on a critical incident form. We felt this was sufficient to prevent what happened from happening again to other patients at the Trust. However, the Trust had not told Mr T about this or apologised for the failing in communication.

At our recommendation, the Trust wrote to Mr T to acknowledge and apologise for the failing in communication, and told him about the action it had taken to prevent the failing from happening again.

Organisation(s) we investigated

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 733/January 2015

Trust failed to arrange follow-up appointment for child but realised this and provided suitable remedy

Miss V complained about the inadequate care and treatment of her son in connection with a potential operation to remove his adenoids. She said that the Trust failed to arrange a follow-up appointment for her son and she also complained about the way it had handled her complaint.

What happened

When Miss V noticed that her two-year-old son had difficulty eating and was snoring at night, she took him to an ear nose and throat (ENT) consultant in spring 2013. Her son was referred to a specialist in ENT surgery and after an initial assessment, he was considered for possible surgery on his adenoids. The adenoids are small pieces of tissue at the back of the nose. The operation did not happen, however, because he had very little adenoid tissue. Miss V's son should have had a follow-up appointment after eight weeks, but, because of an administrative error, the appointment was delayed until several months later. By this time, Miss V's son had developed other medical conditions, including glue ear and speech delay. Miss V complained that the delay in arranging the follow-up appointment for her son had led to him developing the other medical issues.

What we found

We did not uphold this complaint. There was no evidence to suggest that the delay in booking a follow-up appointment resulted in Miss V's son's additional medical conditions. The Trust apologised for the delay and for the anxiety that it had caused. It acknowledged that the delay had been caused by an administrative error by a member of staff. The Trust had identified the staff member, explained the impact of their error and arranged additional training for them. We felt that the Trust's response was an appropriate remedy.

Organisation(s) we investigated

City Hospitals Sunderland NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 734/January 2015

Emergency department failed to record prescribed medication

An emergency department did not record that it had prescribed a woman antisickness medication.

What happened

Miss G went to the Trust's emergency department three times in 15 days with chest pain and other symptoms such as vomiting, loss of appetite and dizziness. On each occasion, staff carried out chest X-rays and blood tests. Trust staff found no cause for concern the first time Miss G went to the emergency department and did not prescribe medication. At the second visit, staff diagnosed Miss G with a viral chest infection and gave her painkillers. At her third visit, clinicians found Miss G had pneumonia and prescribed antibiotics and antisickness medication.

Miss G complained that the Trust should have diagnosed her pneumonia sooner. She also complained that there was no record in her notes about the fact she had been vomiting, even though she was prescribed antisickness medication.

What we found

We partly upheld this complaint. The Trust had made a reasonable diagnosis on each occasion. Although there was an appropriate record of Miss G's history of vomiting, we were concerned that there was no record of the antisickness medication that the Trust had admitted prescribing.

We did not consider that this led to any harm to Miss G, but we were concerned about the implications of this poor record keeping for other patients.

Putting it right

The Trust shared our investigation finding with all emergency department staff who prescribe medication.

Organisation(s) we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

South East

Summary 735/January 2015

Surgeon failed to warn patient about risk of postoperative pain

When Mrs J had an operation, the surgeon only told her about the risk of infection. He should have told her about the risk of pain as well.

What happened

Mrs J had a minor surgical procedure and was discharged from hospital the same day. She had expected her recovery time to be one week. Her wound became infected within a couple of days, and needed antibiotics. Mrs J remained in severe pain and went to A&E, where staff prescribed her strong pain relief. She was unable to get a follow-up appointment with her surgeon for several days so went back to A&E, where she was admitted for assessment. Mrs J was discharged the following day.

Mrs J complained to the Trust about her experiences. She also said that she had had to spend money on prescriptions and private treatment for pain after a procedure she had understood to be straightforward, and she had needed to have six weeks' sick leave from work.

What we found

Mrs J suffered known complications of the surgery she had. The complications were not caused by failings by the Trust. However, Mrs J was not made aware preoperatively that pain is a common complication of the procedure she was having. This was a failing and although it would not have changed her overall experience, she would at least have been more prepared.

Putting it right

The Trust apologised to Mrs J for giving her incomplete information about the risks of the procedure. It also took action to learn from her experience.

Organisation(s) we investigated

United Lincolnshire Hospitals NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 736/January 2015

Trust assessed man as at high risk of suicide 11 days before he took his own life

Ms D believes her son's death could have been prevented if the correct action had been taken following a mental health assessment.

What happened

In spring 2013 Ms D's son was urgently referred by his GP to the Trust's mental health unit. A registered mental health nurse carried out an assessment and it was decided not to admit him to hospital but to refer him to local drug and alcohol services. The assessment identified Ms D's son as at high risk of suicide. Ms D's son was also advised to stop taking medication his GP had prescribed. Very sadly, he died 11 days later.

What we found

We partly upheld this complaint. Ms D's son was properly assessed by the Trust and that assessment included sufficient detail to support the conclusions reached. However, the nurse did not discuss the case with more senior colleagues as should have happened. Although the Trust had recognised that was the case, it had not adequately addressed that failing. In relation to the advice given about medication, the Trust had already explained what had happened and had taken appropriate action to address the failing it had identified.

We found no evidence that Ms D's son's death would have been prevented but we recognised that Ms D had been left with uncertainty because of this failing.

Putting it right

The Trust wrote to Ms D to apologise for the upset, worry and uncertainty she suffered and continues to suffer because her son's case was not escalated as it should have been. It paid her £500 compensation.

It also explained what action it has taken to make sure that escalating high-risk cases is embedded in the culture of the team and how that is being monitored to make sure it happens.

Organisation(s) we investigated

Pennine Care NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 737/January 2015

Nervous dental patient had a poor experience

Mr K complained that he received poor dental care and treatment whilst under sedation. He said this meant he had to pay for treatment he did not consent to, and had to take more time off work, pay check-up fees, and lose money. He said he suffered inconvenience, distress, worry and pain.

What happened

Mr K has dentophobia, a fear of dentists. In 2013 he visited his usual dentist and was told that he needed various treatments, namely several fillings, teeth extraction and possibly root canal treatment. Mr K's dentist told him that this treatment could be done under sedation at another dental practice (the Practice) because of his dentophobia. The dentist referred Mr K to the Practice for the work to be carried out.

The Practice told Mr K that it could not do all the work at one visit. Soon after, Mr K had two wisdom teeth extracted under sedation. The Practice then wrongly told him that his usual dentist would need to re-refer him for the remaining work to be carried out.

Mr K returned to his usual dentist, who made another referral to the Practice. When Mr K went back to the Practice, his first appointment was another consultation, not any actual treatment. The Practice told him that it would waive the dental charge of £49 for the remaining work (four fillings) because of the mix up about asking him to be re-referred.

At the final appointment, Mr K had four fillings under sedation. After treatment, Mr K found out that the Practice had asked his granddad (who accompanied him on his final visit) to pay the £49 charge, and his granddad had paid this. He also discovered that a further appointment had been booked for root canal treatment.

What we found

It was reasonable that the Practice removed Mr K's wisdom teeth at the first appointment. However, it was wrong for the Practice to have asked Mr K to return to his usual dentist for a further referral for his filling treatment. It was inappropriate for the Practice to ask Mr K's granddad to pay a dental charge that it had previously agreed to waive.

We could not say with any certainty what happened at the last appointment. This is because Mr K's dental records were poorly completed. Nevertheless it was reasonable that one of his teeth was prepared for root canal treatment.

These failings resulted in Mr K having to take time off work unnecessarily, and incur check-up fees, inconvenience and distress.

Putting it right

The Practice apologised to Mr K and paid him £200. It also told Mr K what it has done to improve its record keeping.

Organisation(s) we investigated

A dental practice

Location

Essex

Region

East

Summary 738/January 2015

Faults identified in care planning by nursing home

Ms V complained about the care given to her late father, Mr T, while he was living at a nursing home owned by the Park Homes UK group of care providers. Ms V said that her father felt suicidal because of the lack of support from staff at the care home, and this distressed and upset her. She was seeking financial redress as a result of her complaint.

What happened

Mr T had a history of falls and needed support to help him to and from the toilet. He used a call buzzer to request assistance.

Ms V was worried by the number of falls her father had and the length of time it took for staff to help him after his falls; that staff did not minimise the risk of falls; that the nurse in charge did not investigate his concerns appropriately, and that staff did not administer medication consistently.

Ms V said that her father felt suicidal because of the lack of support from staff at the care home, which caused her distress and upset. On one occasion Mr T was found on the floor in his room. Mr T's family later noticed a large bruise to his head that had not been identified.

On another occasion, staff did not answer Mr T's call buzzer when he wanted to use the toilet. Mr T then telephoned his daughter using his mobile phone. Ms V says that she stayed on the telephone with her father for around twenty minutes, but the call buzzer was not answered. Subsequently, the nursing home arranged for a pressure sensor to be used to identify when Mr T climbed out of bed.

Ms V first complained to the home about the care given to her father in winter 2013.

What we found

Although there was evidence of some care planning, there was fault in the nursing home's falls prevention. The individualised care plan was not in line with national guidance. This meant that Mr T's risk of falling was not minimised. However, the faults we identified did not result in harm to Mr T.

Staff did not respond to call buzzers in a timely manner. However, the nursing home had already made changes that went some way to putting this right. The nursing home responded appropriately following Mr T's fall and there was clear documented evidence that showed an appropriate examination had taken place and there was no sign of bruising at that stage.

There was fault in the nursing home's complaint handling, which did not help resolve the complaint and made Ms V's distress worse. A request for access to records was also ignored.

Putting it right

The nursing home accepted our recommendations and acknowledged the failings identified in our report and apologised for them. It paid £500 to Ms V to recognise the distress caused as a result of the faults we found. It responded to her information request, and produced an action plan to address the faults identified.

Organisation(s) we investigated

Park Homes UK

Location

Bradford

Region

Yorkshire and the Humber

Summary 739/January 2015

Older woman was correctly moved from her care home following concerns

Ms B complained that her mother, Mrs A, died because of an inappropriate transfer between a care home and a nursing home. Ms B said that the decision to move Mrs A was made without due consideration and that she was moved too far away from her family. This caused Mrs A distress and meant that she was alone when she died.

What happened

Mrs A went into the care home in early 2012 after her health worsened following a stroke. The local authority began working with the care home on issues about the quality of care in summer 2012. In spring 2013, after receiving an alert from the Care Quality Commission, local authority officers reviewed Mrs A's care plans at the care home and found they did not reflect her needs. The officers also found other issues with the care home. The local authority told the Clinical Commissioning Group's (CCG) continuing healthcare team about what it had found.

The local authority asked Ms B if she had any concerns about her mother's care. Ms B had none and was happy about Mrs A's care. Later in spring 2013, a community nurse found that Mrs A was sore at the base of her spine and could no longer bear weight. The nurse felt the care home could no longer meet Mrs A's needs, and the CCG agreed to visit and assess her. A local authority officer and a continuing healthcare assessor visited Mrs A and decided she needed a nursing home placement to meet her needs. They arranged overnight nursing from another team and nursing home staff. Ms B was happy with this.

Eventually the local authority and CCG agreed to move Mrs A to a nursing home very soon. They were aware that Mrs A would be isolated by a move and that this would be distressing, but they felt that the move was in her best interests. Ms B was unhappy about the move, which took place by ambulance.

Mrs A remained unwell and died several days after arriving at the nursing home.

What we found

We investigated this case jointly with the Local Government Ombudsman. We found maladministration in that the CCG did not formally assess Mrs A in the care home before any issues were raised. However, we did not find any fault in the CCG's decision to move Mrs A to the nursing home. We did not find fault with the way in which the local authority investigated the alert that was raised about Mrs A's care.

Putting it right

The CCG apologised for the distress caused when it did not assess Mrs A between early 2012 and spring 2013. It agreed to produce an action plan to show how it would learn from this.

Organisation(s) we investigated

West Hampshire Clinical Commissioning Group (CCG)

Hampshire County Council (investigated by the Local Government Ombudsman)

Location

Hampshire

Region

South East

Summary 740/January 2015

Son was unhappy about his mother's care and medicines management on hospital ward

Mr K complained about his mother Mrs P's care when she was on a hospital ward. He was unhappy about how staff managed her medication and that she fell while on the ward.

What happened

Mrs P suffered from lung cancer and was diabetic. After she fell one evening in early spring 2013, Mrs P went to A&E at the Trust's hospital. She had a head injury.

A doctor saw Mrs P and carried out various tests and a scan. The scan showed a large abnormal area in the brain, which clinicians thought was likely to be metastases from her lung cancer.

In the early hours of the next morning, staff admitted Mrs P to the acute medical unit at the hospital. She had suspected brain metastases and a possible sepsis infection. Staff put in place a treatment plan of rehydration and intravenous antibiotics. Mrs P stayed in hospital for 11 days. She died soon after from lung and brain cancer.

Mr K made a formal complaint to the Trust on behalf of his mother. He said that staff did not assess Mrs P's mental capacity after she went to A&E and the acute medical unit. He felt that this led to her refusing her medication; that she fell twice when she was in hospital, and the rails on her bed were not always raised; that there were shortcomings in recording her medication so her diabetes was not managed well and there was confusion about the medication she needed. In addition, he said that staff did not record nursing handover information properly; that there was a delay in treating Mrs P with steroids; that Mrs P was not cleaned after a meal, and that doctors made inappropriate comments, which Mr K overheard.

What we found

We partly upheld this complaint. There were failings in the Trust's care of Mrs P during her stay in hospital. We were satisfied that the Trust had acknowledged several of these failings and had taken the appropriate steps to minimise the risks of such incidents happening again. However, there were additional failings that it had not adequately addressed.

We concluded that the failure to prescribe Mrs P's insulin affected her blood glucose readings. High readings were probably caused by staff failing to give Mrs P her usual short- and long-acting insulin one evening and the following morning. However, this failure did not have any long-term effect on Mrs P's condition. We concluded that the Trust did not make sure that the medicines staff prescribed for Mrs P when she was in A&E corresponded to those that she was taking before admission. The Trust failed to carry out a nursing assessment and develop a nursing care plan for Mrs P. Her nursing care was not planned properly and staff did not evaluate it frequently. When caring for Mrs P, Trust staff did not give care in line with guidance from the Nursing and Midwifery Council.

Putting it right

The Trust reviewed its medicines reconciliation policy and reminded all A&E staff to consider the policy when admitting patients to hospital. It also reviewed its practice of conducting nursing assessments and developing nursing care plans and agreed to give extra staff training where necessary.

Organisation(s) we investigated

Medway NHS Foundation Trust

Location

Medway

Region

South East

Summary 741/January 2015

Failure to assess for continuing healthcare

Mr J complained about the Clinical Commissioning Group's (CCG) failure to carry out a full assessment of his father (Mr J senior's) retrospective healthcare needs, despite evidence that suggested that a full assessment was necessary.

What happened

We had previously asked the CCG to complete a report and a healthcare checklist to decide whether Mr J senior was eligible for a retrospective assessment for NHS continuing healthcare funding. The CCG completed three checklists and decided not to carry out a full assessment of Mr J senior's healthcare needs.

Mr J disputed the outcome of these checklists, which he felt showed that his father qualified for a full assessment.

The CCG acknowledged that two of the checklists suggested that Mr J's father qualified for a full assessment. However, it explained that the period of care for one of the checklists coincided with an acute clinical episode. It said that it was normal practice to allow acute episodes to settle before completing a checklist.

What we found

We partly upheld this complaint. We agreed that the first checklist did not indicate that a full review of Mr J senior's needs was warranted. However, the final two checklists indicated that a full assessment was required.

While the CCG's explanation was reasonable with regard to checklists conducted in 'real time', this was a retrospective review of Mr J senior's healthcare needs. Furthermore the disputed checklist related only to a portion of a period of care for which eligibility was being claimed. As such, we would expect to see an analysis of the whole period, not discounted in any way by comparing it with what would happen in a 'real time' case.

Putting it right

The CCG agreed to complete a full review of Mr J senior's eligibility for continuing healthcare funding for the disputed period.

It also apologised to Mr J for the failings identified in this investigation.

Organisation(s) we investigated

Great Yarmouth and Waveney Clinical Commissioning Group (CCG)

Location

Norfolk

Region

East

Parliamentary and Health Service Ombudsman

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