Parliamentary and Health Service Ombudsman

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

April to June 2015

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and Health Service
Ombudsman

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Contents

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

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

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

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

February 2016

Complaints about UK government departments and other UK public organisations

Summary 937/April 2015

HMCTS's errors did not cause loss of over £400,000

Mr G and his solicitors complained that HM Courts & Tribunals Service (HMCTS) caused a five-month delay in issuing a draft judgment to the parties, which led to the defendant disposing of his assets. Mr G was therefore unable to secure the debt awarded to him by way of a charging order against the defendant's properties.

What happened

Following a hearing at a county court in summer 2012, Judge A wrote a draft judgment but HMCTS did not issue it to the parties as it should have done until early 2013. In that time Mr G and his solicitors contacted HMCTS to find out why the draft judgment had not been issued. They found out in early 2013 that court staff had not sent out the draft judgment and had further compounded the error by incorrectly archiving the court file while the case was still live. Court staff had also poorly dealt with Mr G and his solicitors' correspondence.

The case was referred to a different judge, B, who issued the draft judgment from summer 2012, awarding Mr G over £400,000, to both parties in early 2013. The disclosure of Judge A's draft judgment by Judge B, made the defendant aware that he was liable for the debt and enabled him to dispose of his assets in spring 2013, before the final judgment was prepared in autumn 2013. This meant that Mr G was unable to obtain a charging order against the defendant's properties.

Mr G's solicitors complained to HMCTS on his behalf. They felt that failings by HMCTS in not issuing the draft judgment in summer 2012, together with the further delay in the judgment being handed down, had directly resulted in Mr G being unable to secure the debt. They argued that HMCTS was therefore liable for the money (over £400,000) owed to Mr G. HMCTS accepted that it had handled Mr G's case badly and offered him £550. However, it did not consider that its failings had directly resulted in the losses claimed by Mr G.

What we found

We did not uphold this case. There had been failings on the part of HMCTS that led to a delay in the draft judgment being issued. However, we did not find that these failings resulted in the defendant being able to dispose of his assets. We also found that the decision to issue the draft judgment to both parties in early 2013 had been a judicial one, and that, although there had been a delay between the issuing of the judgment and the judgment being handed down, this was not a result of an administrative error by court staff.

We did not attribute Mr G's losses to errors on the part of HMCTS. HMCTS had made mistakes, but we considered that the £550 already offered before the complaint came to us, was a suitable remedy.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 938/May 2015

UKVI's wrong decision left woman in her eighties stranded abroad

UK Visas and Immigration (UKVI) refused to grant a returning resident visa to a British citizen's mother, leaving her stranded in Eastern Europe for eight weeks.

What happened

Mrs P was an East European citizen who had indefinite leave to enter the UK. When she and her late husband visited Eastern Europe in 2009, he became ill and could not travel back to the UK. After Mr P's death in 2013, Mrs P applied to return to the UK to live with her daughter and son-in-law but her application was refused on the basis that she did not meet paragraph 18 of the *Immigration Rules* because she had been away from the UK for more than two years. The entry clearance officer also said she did not meet paragraph 19 because she had only lived in the UK for fifteen months. Mrs P was severely sight impaired with a number of other diagnosed health problems. Her daughter and son-in-law were not able to remain with her in Eastern Europe and were extremely anxious about her health and welfare. Mrs P's grandson had to go to Eastern Europe to care for her. UKVI reviewed its decision six weeks later and revoked the refusal, granting her a returning resident visa.

What we found

UKVI did not properly and fully consider Mrs P's application at first. It should have taken into account Mrs P's strong ties with the UK and the fact that her stay in Eastern Europe was prolonged through no fault of her own. We found that, on the balance of probabilities, had UKVI acted properly, it would have granted Mrs P a visa. We found that Mrs P's daughter and son-in-law experienced a lot of stress and anxiety because of UKVI's failings and they incurred financial losses. This included loss of income for Mrs P's daughter, travel and other expenses involved in extra journeys to Eastern Europe to care for Mrs P. We also found that they had to employ a solicitor to prepare for an appeal (the decision was revoked before the appeal was heard), which also involved additional expense.

Putting it right

UKVI accepted our findings, apologised and paid Mrs P's daughter, son-in-law and grandson £3,429 in respect of their additional expenses. It also made a consolatory payment of £500 to Mrs P, her daughter and son-in-law in recognition of the distress and anxiety caused.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 939/May 2015

Office of Public Guardian did not supervise appointed deputy for estate

Mrs B complained that the Office of the Public Guardian (OPG) did not monitor the actions of the appointed deputy of her late step-mother's estate. She said she suffered a large financial loss as a result.

What happened

Mrs B's step-mother's financial affairs were controlled by a deputy after she lost her mental capacity. Mrs B complained to the OPG that the deputy gave away increasingly large amounts of her step-mother's money as gifts in an attempt to interfere with an existing will and deprive her of her inheritance. The existing estate was due to go to Mrs B and her sister following their stepmother's death.

Despite annual reports on his decisions (this is to make sure client's funds are being used in their best interests), it took four years before the OPG identified that the deputy's actions may have been inappropriate and beyond the remit of the court order.

The OPG asked the deputy to apply to the court for approval of the gifts. However, Mrs B's step-mother unfortunately died before the application was complete. As such, the OPG took steps to call in the security bond (insurance that protects the assets of the person whose affairs and property the deputy is managing) to recover the money for the estate. It asked the Court of Protection (the Court) to look at the final three years of gifting, but did not include the first two years or money claimed by the deputy for expenses. The Court found that the deputy was entitled to give some gifts. However, it called in over £40,000 from the security bond to reimburse the estate for excessive gifting.

Mrs B remained unhappy that the security bond had not been called in for the full amount spent, and felt she had still lost out on over £30,000.

What we found

We partly upheld this complaint. The OPG had offered reasonable explanations for why it had not included the first two years of gifting or the deputy's expenses in its court application. Also, it was open to Mrs B to pursue this during the proceedings to call in the security bond and this would have been the most appropriate way for the financial loss to have been addressed. We noted that the Court was aware of the outstanding gifts and could have chosen to include it in the application if the judge had wished.

We found that the OPG could have acted sooner and should have supervised the deputy better. However, we were satisfied that any financial loss arising from the deputy's actions over the last three years had been rectified by the Court.

In addition, we found that Mrs B had suffered stress because there were times when the OPG appeared to have brushed off her concerns and this had not been remedied by the Court. The OPG could have handled her correspondence better and it had also failed to notice that the deputy had not reimbursed the estate in full in relation to inappropriate expenses.

Putting it right

The OPG reimbursed £300 underpaid by the deputy for wrongly claimed expenses, paid Mrs B £200 for stress, apologised to her and explained how its supervision practices had been improved.

Organisation(s) we investigated

Office of the Public Guardian (OPG)

Summary 940/June 2015

CPS error led to collapse of trial

The Crown Prosecution Service (CPS) failed to notify Ms A, a victim of crime, that a court hearing had been arranged. As a result, she did not attend and the case was dismissed due to lack of evidence.

What happened

In spring 2013, Ms A was verbally threatened by a man known to her (Mr R) while she was at work. According to Ms A, Mr R threatened both her, and her teenage daughter. Ms A reported the matter to the police and Mr R was arrested. The police charged Mr R and a trial date was set for autumn 2013.

However, due to an administrative error, the CPS failed to tell Ms A about the court hearing. As a result, she did not attend and the CPS prosecutor offered no evidence, and the alleged offender was acquitted.

Ms A complained to us about what had happened and said the CPS had failed to meet its responsibilities to her as set out in the Victims' Code. She said she felt threatened by the alleged offender, particularly as he had been released. She said she had lost confidence in the justice system and felt she was in a worse place than if she had not reported the crime in the first place.

The CPS acknowledged and apologised for its error. However, under its guidance at the time, it was unable to make consolatory payments that may have gone some way to putting things right for Ms A.

What we found

The CPS' error had led to no evidence being offered at the hearing. Although we could not say what the outcome would have been if the hearing had gone ahead, we felt Ms A's uncertainty about this was a significant injustice in itself.

We also found the CPS' failure to meet its obligations under the Victims' Code meant that Ms A had been let down by the system specifically designed to protect people in her position.

Putting it right

Following our investigation, the CPS paid Ms A £2,000 in recognition of the injustice she had suffered.

Since Ms A made her complaint, the CPS has changed its guidance and can now make consolatory payments in appropriate circumstances.

Organisation(s) we investigated

Crown Prosecution Service (CPS)

Summary 941/June 2015

Passport Office failed to deliver passport

Mr C complained that HM Passport Office (HMPO) did not deliver his daughter's passport and failed to accept responsibility for loss, insisting that it was delivered. Mr C wanted HMPO to issue a replacement free of charge and to apologise for the way it dealt with his complaint.

What happened

In summer 2013, Mr C applied to renew his daughter's passport. He used the Post Office 'Check and Send' service and submitted an application to HMPO. HMPO insisted that it had delivered the passport through its secure courier service later that summer and gave the exact time too. Mr C said he was at home that day and time and the passport was not delivered.

When Mr C complained, HMPO failed to see how it was possible that the passport hadn't been delivered. It said he would have to reapply and pay the fee again. It said that the handheld device carried by its couriers indicated the passport had been delivered and a further investigation had not contradicted that. Mr C's MP took up the case but HMPO told him it had conducted a further investigation and monitored the performance of couriers. HMPO was therefore satisfied that the passport had been delivered correctly and so could not authorise a free replacement. As a result, the family did not have a holiday in 2013 and Mr C brought his complaint to us.

What we found

In 2013 HMPO had not kept data showing how many cases there were in each year where it said the item had been delivered but the customer insisted it had not. We found HMPO had not been truthful with Mr C or his MP because it could not properly monitor couriers as it failed to retain appropriate data.

HMPO had also failed to conduct a second investigation as it should have when the delivery remained in dispute. All of this also meant that HMPO failed to communicate effectively with Mr C. HMPO's attitude made Mr and Mrs C feel as though they were being accused of stealing their daughter's passport. On principle they missed their family holiday in 2013 rather than apply and pay again when they had done nothing wrong. Following our investigation HMPO said it was reviewing how it recorded such cases and wanted to generate clearer performance data.

Putting it right

HMPO apologised for its failings and its impact on Mr C and his family, and paid Mr C £500.

Organisation(s) we investigated

HM Passport Office (HMPO)

Summary 942/June 2015

A painful battle for understanding

A farmer applied for a top-up to his government subsidy claim, to help make up for the hardship he had suffered because of foot and mouth disease. But the Rural Payments Agency (RPA) mishandled his application, causing him uncertainty, worry and financial loss.

What happened

The Single Payments Scheme (SPS) was a new European Union (EU) farming subsidy scheme, introduced in 2005. It replaced 11 separate subsidies based on production capacity. It included ways to help farmers who, for some reasons, might lose out financially under the new scheme rules. This included farmers who had only recently started or added to their business who might receive less money than farmers who had been established for many years, and farmers who may have suffered hardship. RPA used funds from the National Reserve to top up payments for farmers in these situations.

In 2001 Mr H had lost his livestock as a result of culls in a foot and mouth disease outbreak. In 2005 he applied to the National Reserve, under its 'Investor (alternative)' category, in the hope that he would meet the rules for a top-up payment because of his hardship. Initially RPA refused his application but in 2007 Mr H successfully appealed the decision. In 2008 RPA wrote to Mr H about his appeal and said it had assessed his case against a different standard from the one it had published in the 2005 SPS guidance. It was clear that RPA had difficulties in deciding claims in this category because the SPS 2005 Handbook guidance was so hard to understand.

In 2008 RPA re-published the National Reserve guidance from the 2005 SPS Handbook and reviewed the decisions it had made in the 'Investor' category since 2005. In 2009 it decided it had to refuse Mr H's claim after all. Bitterly disappointed, Mr H appealed, for the second time, and pressed RPA to explain matters.

What we found

We partly upheld this complaint. The 2005 guidance on the National Reserve 'Investor (alternative)' category was hard to understand. We recognised the difficulties faced by RPA in dealing with applications in this category and the steps it took to put things right by publishing new guidance. However, RPA's failings in the 2005 guidance it gave farmers and its own officials about the Investor category were serious. The clarification it gave in 2008 came too late to undo that earlier failure.

RPA's handling of Mr H's appeal against its decision was so bad, and so far from offering an independent review of the issues, that it failed to be fair and proportionate. The delays meant that any reasonable person in Mr H's position would have reached the point of believing RPA's 2007 analysis of his case, in his favour, was the right one.

However, we were satisfied that a fresh decision on Mr H's application would produce the same outcome for him.

Putting it right

RPA had already apologised to Mr H, refunded his appeal fee and paid him £500 as a consolatory payment. It had given Mr H a fresh hearing and offered him access to a scheme expert to advise him in 2009. It gave him more time to make his representations in 2010 and individual RPA officials also helped make sure Mr H had a fair and proportionate new hearing.

The information in our report gave Mr H the material he needed to make sense of RPA's decision making. However, we recommended that RPA should apologise again to Mr H for the effects of the failings we found, and also pay him a further £500 in recognition of the uncertainty, worry and upset it had caused him. RPA complied with our recommendations. It also offered to give Mr H further explanation for its approach, including a visit by a senior level official.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 943/June 2015

Rotation, rotation, rotation

A telephone call to the Rural Payments Agency (RPA) helpline in 2005 left an organic farmer with a ten-year subsidy headache that cost him thousands of pounds in lost farm income.

What happened

New European Union farm subsidy rules in 2005 meant fruit, vegetable and potato farmers could apply for financial help through the Single Payment Scheme. Mr W, an experienced organic farmer, knew he needed to give the RPA correct details about his crops. Mistakes could lose him subsidy or incur fines. He called the RPA helpline to check what code to use for a field of mixed peas and lupins. It was a more difficult question than it sounded. He used the information he wrote down from the call. But he had been given the wrong information.

Years later RPA discovered the mistake. Eventually, RPA worked out that it had overpaid Mr W more than £15,000 because of the crop code mistake and made other overpayments for different reasons. From 2009 to 2012 RPA took back over £29,000 in subsidy.

What we found

RPA misdirected Mr W about the crop code information to put on his farming subsidy claim form for peas and lupins. His record of the call, made at the time, confirms his memory of what happened. We found no other accessible source of information that he could have used.

RPA also mishandled his 2005 claim form by omitting to check a confusing entry he had made; it mishandled its overpayment decision making; delayed unduly in finding and correcting its mistakes; and, in its complaint handling, put greater responsibility for the mistakes on Mr W than on itself.

It was RPA's misdirection that led Mr W to make mistakes in his 2005 subsidy claim. By the time RPA had given him accurate information about what he should have done, he had lost the opportunity to make valid claims based on correct codes. Recovery of the money it had overpaid him lost him the use of that money. He also had to spend more time working on his subsidy claims than he would have done if RPA had acted properly. Mr W used professional advice which, without RPA's failings, he would not have needed. The experience and delay were frustrating and stressful.

Putting it right

RPA accepted our recommendations and agreed to look again at its decision that Mr W made the mistake and that he should have known he had received too much subsidy. It reimbursed Mr W more than £15,000 that it had previously recovered and paid him over £4,000 that he should have received in 2005. It also paid interest on the money it incorrectly recovered. Lastly, RPA reimbursed the professional fees Mr W incurred for advice and made a consolatory payment of £250.

RPA also updated the text of its letters about overpayments so that its customers understood decisions related to recovering subsidies and that they had a right of appeal.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 944/June 2015

Warm Front Scheme application cancelled without fair warning

Ms G complained about the Department of Energy and Climate Change's (DECC's) decision to cancel her application under the Warm Front Scheme. She said that as a result, she suffered from lack of adequate central heating and hot water in her home, which adversely affected her health and day-to-day living.

What happened

Ms G successfully applied to the Warm Front Scheme for a new central heating system. DECC contracted Carillion to carry out the installation work. However, the installation work was postponed and there were delays over many years. It is difficult to say for certain the reasons for this (due to differing versions of events and lack of primary evidence), but they included disagreements about what work was to be carried out and what Ms G needed to do to get her home ready for the work.

Carillion subsequently cancelled Ms G's application because, according to it, Ms G had not carried out the preparatory work. DECC reviewed this decision twice, but did not change it.

What we found

Carillion did not clearly explain Ms G's responsibilities to her, or the consequences of not meeting those responsibilities, before it made the decision to cancel her application. Carillion had opportunities to put that right when it twice revisited its decision but did not do so. Its actions were failings. Those failings meant Ms G was denied the opportunity to make a fully informed decision about the installation work, and she then had the inconvenience of pursuing a complaint about it.

Putting it right

DECC apologised for the failings and the impact they had on Ms G. It has also used our findings to improve the way that it, and the organisations it is responsible for, work.

We also recommended that DECC should find and commission a contractor to install Ms G's heating system, and that it should make it clear to Ms G what her responsibilities are, the deadline for her to complete the work, and the consequences of not doing so.

Organisation(s) we investigated

Department of Energy and Climate Change (DECC)

Complaints about the NHS in England

Summary 945/April 2015

War pensioner waited 18 months for travel expenses to be paid

Mr D made a claim to the NHS for travel expenses to be paid for trips to have an artificial limb fitted. He was entitled to claim because of his status as a war pensioner and not because of low income. NHS Business Services Authority (NHSBSA) took over a year to agree to pass his claim for payment.

What happened

Mr D was a war pensioner and as such was entitled to claim expenses for the cost of travel to fittings for a prosthetic limb. This entitlement was outlined in the official guidance relating to this matter. Mr D made a claim for travel expenses and NHSBSA turned it down because he did not meet the eligibility criteria for the NHS Low Income Scheme (LiS).

Mr D explained to NHSBSA that he was entitled to claim because of his status as a war pensioner and not under the LiS. He then had to wait for 13 months for NHSBSA to acknowledge the validity of his claim and forward it for payment.

What we found

We could see that Mr D had explained to NHSBSA which policy showed that he was entitled to claim and the guidance seemed quite clear. Despite this, NHSBSA took over 13 months to agree to forward his claim for payment. There was no evidence to show that anyone took any action until Mr D followed this up and there were months where no action was taken to follow up the claim.

NHSBSA only resolved the situation when we became involved.

Putting it right

NHSBSA apologised for the distress caused, explained the steps it had taken to make sure the relevant policy was properly applied in the future. It also paid Mr D £600 in recognition of the frustration and inconvenience caused by the wait for his expenses to be refunded.

Organisation(s) we investigated

NHS Business Services Authority (NHSBSA)

Location

UK

Region

UK

Summary 946/April 2015

A flawed mental health assessment caused family considerable distress

Mr and Mrs L complained that the Council and the Trust relied on a 'desktop assessment' that wrongly accused them of physically and emotionally abusing their daughter, Miss L, and withholding money from her. They said the assessment defamed their character, breached their confidentiality, and also led to the inappropriate withdrawal of mental health services for Miss L. This caused considerable distress to the whole family.

What happened

Miss L was diagnosed with Asperger syndrome. She came under the care of the Trust's community mental health team (CMHT) between late 2008 and early 2009. In 2009, Miss L was assessed under the Mental Health Act and detained in hospital under section 3 for treatment. On discharge from hospital, Miss L received section 117 aftercare (which imposes a duty on health and social services to provide aftercare services to certain patients who have been detained under the *Mental Health Act*).

In early autumn 2010 the Council commissioned a desktop assessment (which involves an assessment of the papers on file) of Miss L's condition and needs. The report on this assessment was completed in late 2010 and shared with Miss L soon afterwards. Miss L was discharged from section 117 aftercare (and the Trust's care) at this time.

Mr and Mrs L said that the inappropriate withdrawal of mental health services left Miss L without the support she needed to help manage her condition. She was also 20 weeks pregnant at that time. The use of this assessment also had a lasting impact on their family because the views expressed about Mr and Mrs L in the assessment questioned their ability to care for their grandchild (Miss L's child), which was subject to an investigation by the Council.

By bringing their complaint to us, Mr and Mrs L wanted the people responsible for completing the desktop assessment to be held accountable. They also wanted a financial payment to reflect the injustice caused to them.

What we found

We investigated this complaint jointly with the Local Government Ombudsman (LGO) because it concerned the actions of a local authority as well as an NHS organisation.

We found that the Council and the Trust were at fault in creating a desktop assessment that relied heavily on the authors' personal opinions, rather than the available evidence. The impact of the assessment was far-reaching because there was evidence to show it influenced Miss L's discharge from section 117 of the *Mental Health Act*, and restricted access to the aftercare she was entitled to receive. The inaccurate views expressed about Mr and Mrs L also raised questions about their ability to care for their grandchild.

Putting it right

The Trust and the Council accepted that the assessment was flawed. They both acknowledged the injustice caused to the family and apologised, and each made a payment of £5,000 to Mr and Mrs L in recognition of the impact the flawed assessment had on the family.

The Trust and the Council also produced action plans to address the faults we identified.

Organisation(s) investigated

Avon and Wiltshire Mental Health Partnership NHS Trust

North Somerset Council

Location

Wiltshire

Region

South West

Summary 947/April 2015

Trust incorrectly diagnosed woman with schizophrenia

Ms G complained that she was incorrectly diagnosed with schizophrenia and given medication unnecessarily for many years. She felt that side effects from the medication meant she was unable to work.

What happened

Ms G's GP referred her to the Trust having suffered symptoms of depression. The GP noted in the referral that he felt Ms G was becoming increasingly agitated and detached from reality.

A psychiatrist at the Trust saw Ms G and found that she met the criteria of a major depressive episode. He noted that she had recently given in her notice at work. The plan was for her to continue with antidepressant medication, and see her community psychiatric nurse (CPN) once a week. The psychiatrist at the Trust also saw Ms G a number of times on an emergency basis. He recorded that Ms G was suffering from delusional thoughts. In addition to her antidepressant medication, he prescribed Ms G an antipsychotic drug.

Between spring and summer 2000, Ms G was admitted to hospital twice after taking an overdose. She was noted as having a diagnosis of major depression with psychotic symptoms. Her discharge letter stated paranoid schizophrenia. On the second occasion Ms G was given depot, an antipsychotic medication. The Trust carried out a review in mid-summer 2000 and noted that Ms G had no evidence of psychotic symptoms. Another review also found that she was doing well and had no significant symptoms of a psychotic disorder. Over the following years, Ms G continued with antipsychotic depot and oral medications and was seen regularly by her CPN. She was also regularly reviewed by junior psychiatrists at the Trust. She remained well and was eventually taken off all medication in 2011.

Ms G complained to the Trust in 2012 about a number of issues. However, she felt that the Trust did not deal with her complaint appropriately and so she brought it to us.

What we found

We thoroughly examined the medical records and could find no basis for the diagnosis Ms G was given. We felt that she should have had a different, slightly less serious diagnosis.

We did not believe that the medication she was given was inappropriate and neither could we conclude that the side effects from this caused her inability to work.

However, we found that she suffered an injustice from the impact the incorrect diagnosis had on her. Such a diagnosis may have led Ms G to perceive herself as more unwell than she actually was, which could have disempowered her, leading her to live a more restricted life than she otherwise might.

Putting it right

The Trust acknowledged and apologised for the misdiagnosis and the effect that this had on Ms G. It also paid her £7,500 in recognition of the injustice she suffered.

Organisation(s) we investigated

Hertfordshire Partnership University NHS Foundation Trust

Location

Hertfordshire

Region

East

Summary 948/April 2015

GP delayed referring woman with bowel cancer symptoms

Mr P complained that the delay in his mother's cancer referral led to a missed opportunity to prevent her death.

What happened

Mr P's mother visited her GP on a number of occasions in 2007 and 2008 with bowel symptoms. In spring 2009 her GP referred her to a gastroenterologist. A colonoscopy was performed, which found a large upper rectal tumour. Further investigations showed that the cancer had spread to her liver. Mrs P had chemotherapy, which initially appeared to be successful. However, the cancer returned and she died in summer 2013.

What we found

The General Medical Council had previously found that the GP did not meet the standards expected of a reasonably competent GP. It said there were serious failings in the consultations the GP had with Mrs P in 2007 and 2008.

Our investigation looked at whether Mrs P's outcome would have been any different had she been referred to a gastroenterologist in 2007.

We found it was not possible to determine at what stage Mrs P's tumour would have been in 2007. We could not say for certain whether or not an earlier diagnosis would have made a difference to Mrs P's eventual outcome. However, we found that the Practice's failure to refer Mrs P sooner represented a missed opportunity that could have resulted in an earlier diagnosis and treatment, and possibly led to a different outcome.

This injustice to Mr P can never be remedied. He will never know for sure whether his mother would have survived longer than she did. For this reason we decided to partly uphold the complaint.

Putting it right

We were satisfied with the measures the Practice had put in place to help prevent a similar experience for patients in the future. However, we felt there was still an outstanding injustice to Mr P. The Practice accepted our recommendation and paid Mr P £1,500 in recognition of this.

Organisation(s) we investigated

A GP practice

Location

Cheshire

Region

North West

Summary 949/April 2015

Trust's delay in providing medical records caused stress and anxiety

Mr M complained that the Trust's delay of almost three years to give him a copy of the scan images from his echocardiogram caused him anxiety and stress. He wanted a consolatory payment and for the Trust to improve the way it stores and accesses its archived data.

What happened

In summer 2011 Mr M contacted the Trust to request a copy of his 2004 echocardiogram (sound waves used to build up a detailed picture of the heart). He wanted to give it to his doctor so he could compare the results with a more recent echocardiogram he had done. This would allow the doctor to provide a view on any deterioration or improvement in Mr M's condition.

Due to the changes in the technology used to archive its medical records, the Trust initially advised that it could not provide a copy of the scan images. The Trust advised Mr M that in such circumstances it would issue the reports that accompanied the scans, which it said would be sufficient for the purpose he intended. Mr M disputed the Trust's explanation and again requested a copy of the scan images.

After a lengthy period of further discussion between the Trust and Mr M, and an additional formal complaint, the Trust agreed to obtain a copy of the scan images from its archive and send it to him. However, the difficulty in obtaining the images, caused by the old technology at the time of archiving meant that he experienced almost a three-year delay from his initial request of summer 2011, to when he actually received a copy of the scans in spring 2014. The situation caused him inconvenience, anxiety and stress.

Mr M brought the complaint to us because the Trust declined his request for a consolatory payment and he wanted it to acknowledge that the system it had in place to manage its archived medical records at the time was inadequate.

What we found

We partly upheld Mr M's complaint. From the complaints documents provided by the Trust it was clear that the decision not to provide the copy of the scan images was due to the difficulty and expense of retrieving the data from its previous records management system.

However, Mr M had a right to request the information held by the Trust in his medical records and it was not his fault that the Trust had stored this data in a way that was difficult and costly to access. Although we considered that the report of the scan contained relevant information, a copy of the scan itself was what Mr M requested. We therefore found that the initial decision not to take the necessary steps to give Mr M a copy of the scan from 2004 was unreasonable.

We concluded that the length of time taken to provide Mr M with a copy of his scan was indeed excessive and had caused him anxiety and stress.

We found that the Trust did not adhere to the Department of Health guidance when migrating from its previous records archiving system to the updated record management system in 2009. This was clearly evident in the difficulty the Trust experienced while retrieving the data Mr M requested. However, we were satisfied that as a result of his experience, the Trust purchased the equipment used to retrieve the data stored on the previous records archiving system. The Trust would be able to comply with any future requests for data in a more reasonable timescale than that experienced by Mr M.

Putting it right

The Trust gave Mr M a consolatory payment of £200 to address the delay in providing a copy of the scans.

Organisation(s) we investigated

Worcestershire Acute Hospitals NHS Trust

Location

Worcestershire

Region

West Midlands

Summary 950/April 2015

A flawed process combined with human error caused distress and financial loss

Mrs B complained that the Council failed to give the Trust the contact details of her late brother's next of kin, despite having this information in its possession. She said this led to the Trust cremating her brother's body without the family's knowledge. She said it also led to loss to his estate due to ongoing tenancy payments following his death, and charges for storing his body.

What happened

Mrs B's late brother, Mr C, died in hospital. The Trust had no details about his next of kin. The Trust's bereavement services manager contacted the Council and asked it to use its statutory powers to enter Mr C's property and gather information to identify his next of kin. The search took place and the Council found documents relating to Mr C's financial affairs, and letters between him and his family. The Council officers created a schedule of the items, and placed them in an envelope with the keys to Mr C's property. Unfortunately, the envelope was mislaid, and the Council did not inform the Trust of its findings.

The Trust arranged the cremation of Mr C's body. Around the same time, Mrs B contacted the Trust, having learned of Mr C's death through his GP. The bereavement services manager contacted the Council. The Council discovered the envelope containing Mr C's possessions behind a cabinet and returned the items to the Trust.

Mrs B said as a consequence of this failing she and her family suffered grief and distress, particularly with respect to losing the opportunity to attend her brother's funeral. She also said that her brother's estate suffered financial loss, specifically with ongoing rent payments and charges for storing his body for four months. Mrs B wanted the Council to provide a fair remedy to the injustices she had suffered.

What we found

We investigated this complaint jointly with the Local Government Ombudsman (LGO) because it concerned the actions of a local authority as well as an NHS organisation.

The Trust was legally responsible for arranging Mr C's funeral. The Council's involvement was to assist the Trust's enquiries by using its statutory powers to carry out the property search. The Council initially responded to the Trust's request for assistance appropriately, by entering Mr C's property and gathering relevant information. The Council was at fault in misplacing the information. Having gathered vital information that would have enabled the Trust to contact Mr C's family, it should have made sure that it was returned at the earliest possible opportunity.

The Trust was also at fault because it did not seek confirmation from the Council about the outcome of the property search before arranging Mr C's funeral.

The fault on the part of the Trust and the Council caused Mrs B additional shock and distress, and deprived her of the opportunity to attend Mr C's funeral. The Trust confirmed there was no charge for storing Mr C's body, and an invoice from the funeral director showed no evidence of any costs.

However, we found that if the faults had not occurred, the executors of Mr C's estate would have been in a position to start settling his affairs earlier. Instead, two months of rent and utility bills were paid unnecessarily from Mr C's estate.

Putting it right

To remedy the injustice, the Trust and the Council agreed to write to Mrs B to acknowledge their failings, apologise, and explain what action had been taken to prevent these from happening again. The Trust and the Council paid Mrs B £650 in recognition of the distress caused and for the loss of opportunity to attend Mr C's funeral. Because the Trust was legally responsible for arranging the funeral, we considered it had greater responsibility here. The Trust paid £500 and the Council paid £150. We considered the Trust and Council's errors played an equal role in the injustice to Mr C's estate. They both paid just over £374 to cover the costs for the period of two months when bills were unnecessarily paid by the estate.

Organisation(s) we investigated

King's College Hospital NHS Foundation Trust

London Borough of Lambeth

Location

London

Region

Greater London

Summary 951/April 2015

Poor communication meant dying man's wishes were not heard

Mrs J complained that failures in communication meant that she did not know that her husband was dying and this led to him being admitted to hospital when he wanted to die at home.

What happened

Mr J had terminal cancer and his legs had been gradually weakening. One morning Mrs J was unable to get her husband to the toilet so she requested the assistance of a Hospice at Home nurse. The nurse believed that Mr J was dying and she inserted a catheter and gave him a sedative. The nurse arranged for him to be admitted into a private hospital as it was felt that Mrs J needed help caring for her husband in his last few days. Once admitted to the hospital Mr J was declared to be approaching the end of his life and he was started on an end-of-life pathway. Days later he died in the private hospital.

Mrs J did not believe that her husband was dying and felt the nurse did not do a thorough examination to make that decision. She did not believe that her husband required a sedative and said the nurse did not discuss her opinion that Mr J was dying or the options with Mrs J. Mr and Mrs J wanted Mr J to die at home. Mrs J believed that the nurse influenced the consultant's decision at the private hospital that Mr J was dying and this in turn led him to be put on the end-of-life pathway when he was not in fact dying.

What we found

There were no failings in the treatment provided to Mr J because the use of the catheter and the sedative were appropriate. The nurse's judgment that Mr J was dying was reasonable and this did not influence the consultant's opinion because he stated that he made his own decision based on his own examination of Mr J. We did find failings with the communication between the nurse and Mrs J because she should have made it clearer that she believed that Mr J was dying and then had a discussion with Mrs J as to how they wanted it to happen. The wishes of the dying person should always be sought and complied with if possible, which did not happen here. However, the Hospice, which had provided the Hospice at Home nurse, had already apologised to Mrs J and put systems in place to make sure that communication was improved for future patients. We therefore, did not uphold the complaint.

Organisation(s) we investigated

A hospice

Location

Ipswich

Region

Suffolk

Summary 952/April 2015

Excessive delay in carrying out hip surgery caused unnecessary pain, distress and frustration

Miss R complained that it took the Trust 72 weeks to arrange her hip surgery. This caused her frustration and distress, as well as unnecessary pain.

What happened

Miss R was initially investigated for stomach symptoms, which turned out to be a cyst in her hip. She saw a locum consultant who wanted the radiology team to look at her scan results. However, the locum left the Trust and his work was not picked up until Miss R repeatedly followed it up herself. The gastroenterology clinic saw Miss R and referred her to orthopaedics for removal of the cyst. However, the orthopaedic clinic referred her to a consultant radiologist to remove the cyst guided by an ultrasound. There was nothing in the records to show that this procedure took place. Again Miss R followed it up but the Trust told her it could not speed things up for her because she had been waiting less than 18 weeks (the maximum waiting time for referral to treatment). This was incorrect as she had already been waiting 15 months by this time. Miss R said this was the first time she had been made aware of the 18-week referral to treatment rule.

Miss R continued to contact the Trust for updates, and eventually had her surgery in early 2014, 17 months after she was first referred by her GP.

What we found

There was no system in place to pick up work from the departing locum consultant who first saw Miss R. This caused a clear delay in the process; it was three months before Miss R was referred to orthopaedics. Even when she had seen the orthopaedic surgeon, it was then another 21 weeks before she was seen again, and another 15 weeks before she had her surgery.

We found that the Trust breached the national 18-week referral to treatment rule. Miss R's case was a straightforward one, and this was an unreasonable and significant delay. Miss R was 'lost in the system' on more than one occasion, and the Trust's communication with her about what was happening was poor. Had the Trust been proactive about following up her treatment and keeping her on the correct pathway, it is likely she would have had her surgery sooner, and possibly within the 18 weeks set out in The NHS Constitution.

The delay caused Miss R a great deal of frustration and distress, as well as an increasing amount of pain. However, as this condition is caused by degenerative changes to the hip joint, it would have worsened anyway. We did not find that the delay caused Miss R's condition to worsen or impeded her recovery from surgery. But we found that the delay caused her pain for a much longer period than was necessary.

Putting it right

The Trust accepted our recommendation to apologise to Miss R for the failings we found and the impact they had on her. It also paid her £2,500 in light of the distress, frustration and unnecessary pain she experienced.

The Trust also produced an action plan outlining the steps it had taken to improve its services in future, including how it would make sure that it follows up on work from departing clinicians, how it will work to prevent a recurrence of the administrative errors in Miss R's case, and how it will improve communication with patients about the 18-week referral to treatment rules.

Organisation(s) we investigated

University Hospital of North Staffordshire NHS Trust

Location

Stoke-on-Trent

Region

West Midlands

Summary 953/April 2015

Trust dealt adequately with patient's complaint

Mrs E suffered a complication when she went into labour. She called 999 but complained that the paramedics did not give her proper treatment and took too long to transfer her to hospital. She gave birth to her son but he died a few days later. This caused Mrs E emotional distress and loss of faith in the 999 service.

What happened

When Mrs E went into labour, she suffered a complication when her umbilical cord prolapsed. Mrs E phoned 999 for an ambulance, which arrived promptly at her house. The paramedics that attended Mrs E undertook some observations and prepared her for transfer to hospital.

Due to the serious and time critical nature of the complication, the paramedics inserted a cannula into Mrs E's arm, transferred her to the ambulance on a stretcher and contacted the maternity unit at the hospital to pre-warn them of Mrs E's arrival, and to seek advice on how to manage Mrs E in the ambulance.

When Mrs E arrived at hospital she was taken to the maternity unit where she gave birth. Sadly Mrs E's baby died a few days later as a result of injuries caused by the prolapsed umbilical cord.

What we found

We did not uphold this complaint. The paramedics acted in line with relevant guidance when they inserted a cannula into Mrs E's arm and transferred her to the ambulance. We also found that they acted in line with established good practice when they contacted the hospital to inform them of Mrs E's arrival. The time taken to transfer Mrs E to hospital was also reasonable.

However, we also found that the paramedics were unaware that the relevant guidance suggests that a single attempt should be made to reinsert the umbilical cord. Although there are risks associated with handling the umbilical cord, we recognised that the paramedics needed to make a clinical decision whether to reinsert the cord. As the paramedics were not aware of this part of the guidance, they were not in a position to make a sound clinical judgment and as such we found that this was a failing and we considered the impact this had.

Our obstetrician adviser explained that a paramedic would not be expected to try and relieve pressure on the umbilical cord and that in such a situation there is a very short time frame within which the baby needs to be delivered in order to prevent serious damage.

Because this complication occurred while Mrs E was at home, she did not have immediate access to specialist care and while the paramedics should have been aware of the guidance to make one attempt to reinsert the umbilical cord, this action would not have relieved the pressure on the cord that caused injuries to Mrs E's baby. Even if the paramedics had been aware of the relevant guidance, it is likely that the outcome would still have been the same.

As such we concluded that the Trust's failing was highly unlikely to have caused or contributed to the death of Mrs E's baby.

Putting it right

The Trust appropriately acknowledged its failing during its consideration of the complaint and as a result arranged for the paramedics to attend training and a learning session about the incident. We found that this action was appropriate and proportionate to remedy the failing.

Organisation(s) we investigated

North West Ambulance Service NHS Trust

Location

Cheshire

Region

North West

Summary 954/April 2015

GP practice provided appropriate care and did not delay cancer diagnosis

Mr F complained that the GP practice did not provide adequate care and treatment to his mother, Mrs F, when she presented with pain in her right leg. He said the GP failed to refer his mother for X-rays or scans. As a result, she was not diagnosed with cancer until it was too late to treat successfully.

What happened

Mrs F visited her GP from early 2013 with complaints of swelling and pain in her ankle. She received treatment for this, but by summer 2013 she also complained of swelling in her knee. The GP referred Mrs F to the musculoskeletal department at the hospital.

The hospital noted a swelling in Mrs F's thigh and she was advised to go to A&E. At A&E she had an X-ray and was told that she would need an MRI scan. There was no record of a scan being arranged until Mrs F contacted the hospital in autumn 2013. Following the scan Mrs F was diagnosed with cancer. She died in early 2014. Mr F considered her death may have been avoided had appropriate referrals been made sooner.

What we found

We did not uphold this complaint. The GP made appropriate referrals for the symptoms Mrs F presented with. There was no record of her mentioning a problem with her thigh until after the A&E attendance in summer 2013. The records indicated that the GP took appropriate and timely action when a new problem was identified, and we found no reason to doubt the accuracy of the records.

We found that the A&E discharge letter was lacking in detail and did not give the GP any instructions to arrange further investigations, including an MRI scan. There was a delay in Mrs F having the MRI scan, but this was not a failing by the GP practice.

The GP practice had provided a detailed and thorough response to Mr F's complaint.

Organisation(s) we investigated

A GP practice

Location

Cheshire

Region

North West

Summary 955/April 2015

Delayed referral led to late diagnosis of stomach cancer

Mr A complained that the Medical Centre should have referred his wife for the appropriate investigations at an earlier stage, and that its failure to do so led to her diagnosis of terminal stomach cancer being delayed.

What happened

Mrs A reported ongoing symptoms of weight loss, vomiting, stomach bloating and constipation to her GP in autumn 2013. She attended numerous appointments over the course of the following five months, reporting similar symptoms. In spring 2014 Mrs A was admitted to the A&E department of her local hospital after being examined by a GP. Following further investigations, a diagnosis of terminal stomach cancer was confirmed in spring 2014. Mrs A was admitted to a hospice later, and passed away a short time after.

What we found

The Medical Centre should have referred Mrs A to hospital under the two-week suspected cancer pathway when she presented with her symptoms during two appointments in 2013. Further opportunities were missed before she was eventually referred in early spring 2014.

It is likely that, if Mrs A had been referred in 2013, her cancer would not have been operable and that her treatment would have been palliative. This treatment could have led to an improvement in her symptoms and she may have had longer to live. An earlier referral would also have given Mr A an additional four to five months to prepare for losing his wife.

Before our investigation, the Medical Centre apologised to Mr A and put in place measures to reduce the chance of a similar episode occurring again in future. We found that the Medical Centre did not go far enough to remedy the injustice caused to Mr A by its failure.

Putting it right

Following our investigation, the Medical Centre paid Mr A £2,000.

Organisation(s) we investigated

A medical centre

Location

London

Region

Greater London

Summary 956/May 2015

Trust failed to handle complaint well which added to family's distress

Ms T complained that the Trust handled her complaint about her late father's care and treatment poorly. She said it was necessary to involve a coroner in order to get honest answers to her concerns, and that the prolonged process caused her and her family much stress and heartache, which could have been avoided.

What happened

Ms T's elderly father, Mr D, had been in hospital locally to where he lived, which was in a different part of the country to his daughter. A plan was in place to transfer him to hospital close to Ms T in preparation for a stay with her while he recuperated. However, not long after his transfer between hospitals, Mr D had a fall in hospital, that caused a head injury. He remained in hospital and died a few days later.

Ms T had first complained to both hospitals about his care and treatment before her father's death, sending them a joint letter of complaint. Each Trust sent a separate response, but Ms T was dissatisfied with both responses. She sent a further joint letter to both Trusts and they eventually responded jointly.

In the meantime, an inquest was opened to establish the cause of Mr D's death. The coroner raised concerns, which he said if left unaddressed, could lead to future deaths. The coroner's concern related to record keeping and communication about Mr D's transfer between hospitals and his fall.

What we found

We investigated responses from one of the Trusts, because Ms T was satisfied with the response received from the other.

Our investigation only considered the Trust's complaint handling and did not address Mr D's care and treatment, because an inquest had already looked at this in detail.

There were a number of failings in how the Trust we investigated handled the complaint. We saw inconsistencies in its responses, and it had no evidence to support its account of events. This contradicted the other Trust, which had evidence to support what it said. The Trust based its response on the account of one staff member, instead of gathering evidence from all the people involved, and some information in that response was misleading. The Trust also gave the complainant an initial response before it had completed an internal root cause investigation. It did not then take the findings from the investigation into account when it provided Ms T with further responses.

These failings led to a protracted complaints process for Ms T, causing her additional distress and frustration at a time when she was mourning her father.

Putting it right

After receiving our findings, the Trust gave us information that demonstrated it had already identified failings in its complaint handling processes and had taken action to put them right. This included better communication with complainants, improved management of the investigation, shorter response times, taking more staff statements and completing a root cause analysis (where one is required) before responding to a complaint. We also saw that the Care Quality Commission had inspected the Trust and seen improvements in complaint handling. We therefore did not make any further recommendations.

Organisation(s) we investigated

Wirral University Teaching Hospital NHS Foundation Trust

Location

Wirral

Region

North West

Summary 957/May 2015

Failure to X-ray child's teeth led to root canal treatment

A dental practice did not comply with guidelines for X-rays when it failed to provide B, a child patient, with a particular type of X-ray for four years. As a result, he needed root canal treatment.

What happened

B had a number of appointments with the Practice, including orthodontic treatment, in a four-year period from spring 2010. However, he was never offered any posterior bitewing X-rays (type of X-ray for back teeth) during this time. His mother, Mrs W complained that because of this, extensive tooth decay was allowed to develop in her son's teeth. This resulted in B needing emergency root canal treatment in summer 2014.

Mrs W said root canal treatment would not have been necessary if the Practice had monitored B properly, and this would have a long-term impact on her son. The family spent over £2,600 on having the treatment done privately.

What we found

We fully upheld this complaint. We considered the available evidence and took advice from one of our dental advisers. The Practice had failed to follow relevant guidelines by not offering B posterior bitewing X-rays during the four-year period. During that time there were documented indications that particular teeth, including the tooth that required root canal treatment, needed monitoring. These indicators meant B's risk of decay was increased and the dentist should have taken the X-rays more often.

Had posterior bitewing X-rays been taken, the Practice could have taken preventative measures to reduce the extent of decay in B's tooth, and he would not have needed root canal treatment.

Putting it right

The Practice acknowledged and apologised for the failings we found. It paid B over £2,600 for the cost of the private root canal treatment he had, and paid him £750 in recognition of the overall impact on him for these failings.

Organisation(s) we investigated

A dental practice

Location

London

Region

Greater London

Summary 958/May 2015

Out-of-hours GP service failed to diagnose sepsis

Mr G complained about the care and treatment he received from two GPs from an out-of-hours service. He said their delay in diagnosing sepsis made his condition worse, and because of this he suffered permanent damage to his hand, causing him pain, worry and inconvenience.

What happened

Mr G had a sudden onset of pain in his right hand and called the out-of-hours service. A GP visited him at home and diagnosed Mr G with gout (a form of arthritis) and gave him a painkilling injection. Later that day, Mr G called the out-of-hours service again and a second GP visited him at home. The second GP agreed with the diagnosis and gave Mr G further painkillers.

Mr G went to his own GP three days later and was admitted to hospital with sepsis (a potentially life-threatening complication of an infection) and cellulitis (bacterial infection of the skin). He developed an abscess and needed five operations and intensive rehabilitation, and he was left with suspected permanent damage to his hand.

What we found

The examinations carried out by the out-of-hours doctors were not as good as they should have been, and the written records were poor. As a result of this, there was a missed opportunity to treat the infection earlier, and so Mr G had a poorer outcome than should have been expected.

On the balance of probabilities we found that if the consultations had been carried out as they should have been, Mr G would have had earlier treatment and the infection would not have become an abscess. This would have meant surgical treatment might not have been needed, or it would have been limited to fewer and less extensive operations.

Putting it right

The out-of-hours service agreed that the doctors would take further training to prevent the same thing happening again. During the course of our investigation both doctors started this process. The service agreed to share evidence of the training with the doctors' supervisors, and with the Care Quality Commission who are responsible for inspecting GPs.

Organisation(s) we investigated

North Hampshire Urgent Care

Location

Hampshire

Region

South East

Summary 959/May 2015

Clinical Commissioning Group unreasonably refused to fund IVF

Mr A and Ms B complained about the Clinical Commissioning Group's (CCG's) decision to turn down their request to find IVF treatment to help her conceive a child. The couple complained that the CCG did not adequately consider their individual circumstances and because of this, they were unable to have a child together.

What happened

Mr A was involved in a road traffic accident and suffered an injury to his spinal cord. This left him paraplegic (when either both legs or the pelvis and some of the lower body are paralysed). His recovery was complicated by severe muscle spasms in his lower limbs, which required the insertion of a pump to deliver medication to the spinal cord to help him control this. Since doctors inserted this, Mr A has been unable to ejaculate and his GP and spinal surgeon suggested he seek fertility treatment.

Mr A and Ms B applied for NHS funding for IVF on three occasions and each time the CCG declined this.

What we found

There was no detailed evidence to support the CCG's assertion that it had appropriately considered Mr A's exceptional condition. It also provided no supporting information to demonstrate why Mr A's specific circumstances did not satisfy the exceptionality criteria.

Under the *Individual Funding Request Operational Policy* the CCG has to decide whether an individual has presented evidence of exceptional circumstances as described above. The evidence Mr A provided was clearly recorded in the CCG's documents. However, it was unclear precisely what evidence the CCG had used to base its decision, as this was not included in the records or decision letters.

The CCG had not clearly explained in its decision letters why it had not considered the circumstances to be exceptional in this case. For this reason we found that its decision not to fund the IVF was unreasonable.

There was no clear evidence to support the CCG's decision that the couple had not satisfied the exceptional circumstances criteria as set out in its I*ndividual Funding Request Operational Policy*.

Putting it right

The CCG reconsidered the request for funding under the exceptional circumstances criteria, and provided evidence to support its eventual decision. However, the CCG further declined funding.

Organisation(s) we investigated

A clinical commissioning group (CCG)

Region

South East

Summary 960/May 2015

Dentist provided very poor care to a young patient

A dentist failed to diagnose decay in Miss K's teeth over a three-year period, which resulted in Miss K having four teeth extracted and a crown.

What happened

Miss K, a child, attended the Practice in 2009. She had regular six-monthly appointments with Dentist A until mid-spring 2012. She had fillings on three occasions, but no X-rays were ever taken. When Miss K went for her check-up in early 2013, Dentist A had left the Practice so she saw a different dentist. Dentist B immediately took X-rays and found extensive decay in six of Miss K's teeth. Four of these teeth were so decayed that they needed to be taken out, one needed a crown, and one needed a filling.

Miss K's father complained to the Practice. The Practice said that Dentist A was confident that the care had been in line with good practice and that he had treated Miss K's '*visible*' decay.

What we found

There were significant failings in the care the Practice gave to Miss K, and the extractions and crown could have been avoided if she had received proper care. Treating the '*visible*' decay did not mean that the care was appropriate. The Practice should have taken X-rays to identify any decay which was not visible from a visual examination. Miss K was at high risk of decay, and there were three occasions when the Practice should have carried out X-rays. If X-rays had been taken, the decay in Miss K's teeth would have been diagnosed much sooner, and it is likely that she would only have required fillings rather than extractions.

At Miss K's first appointment with Dentist B, the new dentist, X-rays were carried out which identified the severe decay.

One of the fillings Dentist A carried out was inadequate because it was the wrong type of filling for the tooth. This filling was less hard-wearing than a normal filling and this tooth went on to need extraction. This could have been avoided if Dentist A had done the correct filling initially.

There was no evidence that Dentist A provided any oral hygiene advice to Miss K. Miss K was at high risk of decay, so she should have been given preventative advice. Dentist A should also have treated Miss K's teeth with dental sealant, which can help to prevent decay in high risk patients.

Putting it right

We recommended that the Practice apologise to Miss K and her family, and pay them £5,150. This was in recognition of the pain and discomfort the extractions and the crown caused Miss K, and to enable her to have implants fitted to replace the lost teeth.

Organisation(s) we investigated

A dental practice

Location

Cornwall

Region

South West

Summary 961/May 2015

Trust failed to conduct adequate mental health assessments

Mrs Y complained that the Trust failed to adequately assess her son on two occasions. She said it discharged him inappropriately and failed to alter inaccurate information in his discharge summaries. She also complained that a crisis team failed to record accurate information during a home visit.

What happened

Mrs Y's son, Mr Y, had a history of mental health problems. He became unwell in 2013 and was twice reviewed by a multidisciplinary team (MDT) at the Trust. The team concluded that his behaviour was caused by substance abuse and discharged him from mental health services. The crisis team subsequently saw Mr Y at home but they decided that he did not need treatment. A different consultant psychiatrist from another trust assessed Mr Y later that year and diagnosed him with mental health problems. The psychiatrist detained him under section 3 of the *Mental Health Act* and Mr Y remains in hospital.

What we found

The MDT failed to take sufficient account of Mr Y's medical history or the information Mr Y's family and other Trust staff gave them. The Trust failed to adequately consider the family's request to amend inaccurate information in their son's discharge summary. The crisis team also failed to properly assess Mr Y before deciding that he did not need treatment.

As a consequence of the Trust's failure to adequately assess Mr Y, it lost opportunities to consider steps that might have reduced the possibility of him exposing himself to risk. Although we did not conclude that Mr Y's mental health would have improved had he been adequately assessed, the family suffered distress because the Trust failed to support them and their son. The distress was compounded by the Trust's failure to properly consider Mrs Y's request to amend her son's discharge summaries.

Putting it right

The Trust acknowledged its failings and apologised for the injustice Mrs Y suffered as a consequence. The Trust made a consolatory payment of £1,500, and produced an action plan to prevent the failings from recurring.

Organisation(s) we investigated

Black Country Partnership NHS Foundation Trust

Location

West Bromwich

Region

West Midlands

Summary 962/May 2015

Trust communicated with solicitors rather than patient's family

Mr and Mrs N complained on behalf of Mrs N's late father, Mr R, about the end of life care he received in the community and as an inpatient at the Trust in 2012. Mr and Mrs N also complained about Mr R's nursing care and how the Trust handled their complaint.

What happened

Mr R was diagnosed with liver cancer in early 2012. Doctors advised him that there was nothing more they could do for him and that his care from this point on would be palliative. The Trust's community nursing team cared for Mr R at his home until he was transferred to the Trust's local community hospital where he died in spring 2012.

Mr and Mrs N had several meetings with the Trust to discuss their concerns, and the Trust carried out an investigation and prepared a report. The Trust also created an action plan for future patient care to address the aspects of Mr R's care that should have been better, such as offering the family Macmillan support. The Trust then explained to Mr and Mrs N that it considered local resolution had been exhausted and they should bring any outstanding concerns to us. Mr and Mrs N continued to contact the Trust until the Trust's solicitor's sent them a letter.

The letter said that on some occasions their attitude towards the Trust's staff was '*aggressive*' and '*abusive*' and enclosed a copy of the Trust's policy on habitual complainants. It said that the Trust may consider taking further action, such as legal action, if Mr and Mrs N persisted in contacting the Trust about their complaint.

However, a final meeting took place between Mr and Mrs N and the Trust in spring 2014.

What we found

Aspects of Mr R's care should have been better. For example, the Trust should have offered the family Macmillan support but did not. There were also some gaps in the Trust's record keeping which needed to be improved. However, the Trust had already appropriately acknowledged, apologised for, and addressed these issues.

The Trust had handled Mr and Mrs N's complaint fairly and sensitively and had also taken appropriate action to address areas it needed to improve. However, it was not proportionate or customer focused of the Trust to communicate its concerns about Mr and Mrs N's behaviour via its solicitors. This could and should have been communicated by the Trust itself before involving a legal third party. We could understand that Mr and Mrs N felt threatened by receiving this letter and this would have caused them some distress at the time. Therefore we upheld this part of the complaint.

Putting it right

The Trust wrote to Mr and Mrs N to acknowledge that it did not act in a proportionate or customer focused manner by sending them a letter from its solicitors and apologised for the distress this caused them.

Organisation we investigated

Lincolnshire Community Health Services NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 963/May 2015

Trust acted fairly in moving a women in her wheelchair

Mrs F suffers from a condition that requires her to use a wheelchair much of the time. She was admitted to hospital and complained that the Trust did not respect her rights as a wheelchair user by moving her without her consent.

What happened

After spending several days in hospital the Trust said Mrs F was medically fit for discharge, but kept her in hospital as her community care package had not been finalised. One night she said she experienced flashbacks triggered by the environment on the ward, and this caused her some distress.

Mrs F moved away from the ward but nursing staff twice asked her to return and said they needed to closely monitor her. When she tried to leave the ward again, staff called security officers who, without her consent, moved Mrs F closer to the nurse's station. Mrs F tried to get out of her wheelchair while the security officers moved her but they restrained her to stop her from falling to the floor.

Mrs F discharged herself the next day because she did not feel safe in hospital.

She contacted us because she said she would like to see improvements to services in the hospital. She also wanted to visit the Trust to help reduce the terror she felt about having to go into hospital in the future.

What we found

We did not uphold this case. The nurses had good reason to ask Mrs F to remain on the ward so that they could observe her. They acted appropriately when they called security for assistance, because they had justifiable concerns about her safety.

The security officers did not act in line with Trust policy when they moved Mrs F without her consent. However, they acted appropriately in preventing Mrs F from falling from her wheelchair in case she injured herself.

While the Trust's investigation into her complaint did recognise that it had not treated Mrs F fairly as she used a wheelchair, it missed an opportunity to begin the investigation earlier. As a result it could not interview one of the nurses who no longer worked there. The Trust also suggested that Mrs F could visit the hospital to allay her fears but had later cancelled this visit. We felt that a meeting was a good way to remedy the injustice Mrs F suffered, but that the Trust acted unfairly by cancelling it.

Although we did not uphold this complaint, the Trust agreed to rearrange the visit that was cancelled, to help Mrs F allay her fears of going back to hospital for treatment. It also acknowledged its failing, and all staff now have mandatory training on equality and diversity.

Organisation(s) we investigated

Royal Cornwall Hospitals NHS Trust

Location

Cornwall

Region

South West

Summary 964/May 2015

GP wrongly diagnosed constipation in three-week old baby

Miss B and Mr G complained that their GP practice wrongly diagnosed constipation in their young son, L. They said the GP prescribed an unlicensed medication for L, which a paediatrician later told them should not have been prescribed because of its high salt content.

What happened

Miss B made a GP appointment for her son, L, because she was concerned he had not opened his bowels for several hours. Her son was three weeks old at the time. The GP prescribed paediatric Movicol, a laxative, and Miss B administered it as recommended.

The next day, L developed a rash and Miss B took him to an urgent care centre at a nearby hospital. L was seen by a paediatrician who said it was normal for very young babies not to open their bowels for up to several days. Miss B told us the paediatrician also said L should not have been given Movicol because its high salt content could have been dangerous for him. The experience was very distressing and worrying for Miss B and Mr G.

What we found

We did not uphold this complaint. Although we found failings by the GP practice, it had accepted and taken appropriate steps to address them.

There is nothing in the *British National Formulary for Children* (a reference guide used by doctors across the NHS when prescribing medication for children) to prevent Movicol being prescribed to a baby of L's age. It is an unlicensed medication but it may still be prescribed. Many medicines are unlicensed for use in children because the research carried out to establish whether medicines are safe rarely includes children. This does not mean the medication is unsafe. However, the GP should have told Miss B that he was prescribing a medication that was unlicensed and explained why. He did not do so and this was a failing.

It was unlikely that L had constipation, because he did not have the symptoms as listed in the national guidance on diagnosing constipation in children.

Organisation(s) we investigated

A GP practice

Location

Kent

Region

South East

Summary 965/June 2015

GP practice failed to urgently refer patient

Several GPs at the Practice failed to refer Mr D for an urgent neurology appointment despite his deteriorating symptoms. This meant there was a long delay in diagnosing his Motor Neurone Disease (MND) which caused him additional pain and suffering.

What happened

In early 2012 Ms J, Mr D's daughter, became concerned because her father's speech suddenly deteriorated, he choked when he tried to swallow, and later he had problems walking and with his balance. She took him to the Practice, and one of the GPs referred Mr D to a neurologist, but Mr D could not go to the appointment. This was because his daughter had taken him to A&E with a suspected stroke, and he was an inpatient at an acute stroke unit. Doctors at the stroke unit later discharged him with a diagnosis of small vessel disease, a condition that affects the small arteries in the heart.

Mr D's symptoms deteriorated and in mid-2012 his speech and language therapist asked the lead GP at the Practice to refer him to both a neurologist and an ear nose and throat (ENT) specialist, but the GP only referred him to ENT. During an appointment in June 2012 the lead GP advised Mr D that he had a stroke. In the autumn 2012, the speech and language therapist wrote to the GP again with concerns about Mr D. The lead GP then referred Mr D to a neurologist, although the GP did not treat it as urgent. The referral letter made reference to Mr D having had a stroke.

By the time Mr D saw the neurologist and was diagnosed with MND, he could not feed himself or be fed through a tube, and the symptoms were too advanced for him to have any palliative treatment. He died at the end of 2012.

Miss J believed that the long delay in diagnosis caused her father unnecessary pain and suffering and meant that it was too late for him to receive food at the end of his life.

What we found

The GPs at the Practice missed many opportunities to refer Mr D urgently to a neurologist, and some of their consultations with him were not in line with the General Medical Council's guidance, *Good Medical Practice*. We considered that Mr D's clinical records did not fully reflect his deterioration, and that the lead GP's working diagnosis of 'stroke' was unhelpful and misleading. We found it unacceptable that the lead GP had not referred Mr D urgently because she did not know how to do this on the system she used.

Putting it right

The Practice accepted our findings and recommendations. It apologised for the failings we identified, drew up an action plan to address the failings, and paid Mr D's daughter £4,000 in recognition of the impact the failings had on the family.

Organisation(s) we investigated

A GP practice

Location

Greater Manchester

Region

North West

Summary 966/June 2015

Child's death was avoidable as hospital wrongly discharged him

Mr and Mrs P complained about the care and treatment their son, S, received in hospital, and also said staff were wrong to discharge him. They said their son died as a result of these failings.

What happened

S had complex health needs, including developmental delay, epilepsy and cerebral palsy and had previously suffered from repeated lower respiratory tract infections. In late 2013 his mother was concerned that he was unwell with a high temperature, and called an ambulance. The ambulance took S to the Trust's A&E department at about 9pm. Once there, a consultant in emergency medicine's initial assessment said that S might have sepsis. Doctors gave S paracetamol to control his temperature and monitored him. Between then and midnight, a paediatric registrar gave S intravenous antibiotics.

In the early hours of the following day a second paediatric registrar discharged S. He died at home later that morning from sepsis.

What we found

We upheld this complaint. We found that S's death could have been avoided. There were different accounts of what happened, in particular in relation to the decision to discharge S. We concluded that it was likely to have been at the time S's mother told us it was, and that medical records made at the time were not consistent with the second registrar's explanation for the decision to discharge.

The Trust's initial treatment was appropriate but there was insufficient evidence to support the second registrar's account of the timing of, and reasons for the discharge. It was not reasonable to discharge S so soon, given that there was no evidence of significant improvement, and that had he stayed in hospital it was more likely that he would have survived. The second registrar did not comply with the professional standard that entries in medical records should be made as soon as possible after the event, and if there is a delay, the time of the event and the delay should be recorded.

Putting it right

The Trust provided S's parents with an open and honest acknowledgement of the failings we identified, an apology and a payment of £15,000 in recognition of the fact that S's death was avoidable and that they will have to live with knowing that to be so. The Trust also prepared an action plan describing what it had done to make sure that the organisation and the second registrar had learnt lessons from the failings, so that a similar situation would not happen again. We sent the report to the General Medical Council in connection with the second Registrar's handling, and asked it to consider whether his fitness to practise had been impaired.

Organisation(s) we investigated

St Helens and Knowsley Teaching Hospitals NHS Trust

Location

Merseyside

Region

North West

Summary 967/June 2015

Wife's death may have been avoided

Mr K complained that the hospital should not have given his wife a general anaesthetic because of her pre-existing medical conditions. He believed that, if it had not been given to her, she would still be alive.

What happened

In the autumn of 2013 Mrs K fell and broke her hip. She was taken to hospital and had hip surgery the following day. Mrs K then developed renal and cardiac failure and so her condition deteriorated. Several days after her operation, doctors decided to stop active treatment and provide her with palliative care. Mr K complained that staff failed to properly consult him about this and that he never agreed to a palliative approach. Mrs K died just over a week after her operation.

What we found

The Trust's decision to operate was appropriate and the type and amount of anaesthetic it used was in line with good practice. However, Mrs K's fluid management before the operation was poor, and staff were too slow to react to her deteriorating condition after the operation.

As Mrs K had significant pre-existing medical conditions it meant her risk of dying after surgery was high, even if there had been no failings. Therefore, we did not find a link between the failings and the loss of Mrs K's life.

Nevertheless, the failings meant there was an increased risk of Mrs K developing an acute kidney injury after the operation. In addition, the failings after the operation meant there was a lost opportunity to treat her deteriorating condition quickly.

It was clear from the evidence that these events were extremely distressing for Mr K. The loss of his wife was compounded by concerns that this may have been avoidable if her hospital treatment had been different. This additional distress was caused by the Trust's failings.

Putting it right

The Trust wrote to Mr K to acknowledge the failings we found and apologised for the distress caused. It made a payment of £5,000 to Mr K and also completed an action plan to address the failings we had found.

Organisation(s) we investigated

Portsmouth Hospitals NHS Trust

Location

Hampshire

Region

South East

Summary 968/June 2015

Trust delayed making cancer diagnosis for over 12 months

The Trust missed several opportunities to diagnose Mr S's cancer, so he and his family did not get the support they needed and also lost over £8,000 in benefits.

What happened

Mr S had an excess of fluid in his lungs, so the Trust referred him for a biopsy (a small surgical procedure to take a sample). The results of this were negative and several subsequent scans and tests showed no evidence of cancer. Mr S then developed a painful lump on his back and doctors took a biopsy of this. Unfortunately a machine error at the Trust meant that the biopsy sample was unusable. However, the two consultants involved in his care decided to not take another biopsy of the lump, and assured Mr S it was more than likely a build-up of scar tissue.

The lump remained painful and Mr S developed chest pain. He went to A&E and then was admitted to hospital as an emergency patient. He had a CT scan which showed he had mesothelioma (asbestos-related cancer). Mr S died one month later.

Mrs S said the Trust knew that her husband may have been exposed to asbestos, which increased his risk of developing mesothelioma. She knew that her husband's cancer could not have been cured, but said that if the Trust had done more investigations, her husband could have had earlier treatment which may have reduced his suffering in the final 12 months of his life. She said she and her family suffered a great deal of upset and heartache because of this.

What we found

The initial biopsy test has a well-known 10% risk of giving a false positive result, and the consultant who did the biopsy said at that time that mesothelioma could develop. However, doctors did not discuss this with Mr and Mrs S before his eventual diagnosis.

Our investigation showed that from the time the painful lump developed, Mr S showed clinical signs that should have alerted clinicians to doing more tests. While it was unfortunate that the biopsy sample had been lost, the Trust should have done another biopsy on Mr S. Had it done so, it is likely it that doctors would have found the cancer.

Overall the Trust's care and treatment of Mr S was not in line with established good practice. Had the Trust acted in line with national guidance, it could have diagnosed his mesothelioma 12 to 16 months earlier. This would have given Mr S the opportunity to have treatment and psychological and palliative support. However, it is unlikely that if the diagnosis had been made earlier it would have altered the outcome for Mr S.

Putting it right

The Trust accepted our recommendations and sent Mrs S a letter to acknowledge the failings we found and apologised for the impact of these. The Trust also paid her £2,500 to acknowledge the psychological impact and lack of support it had provided for her because of the delayed diagnosis. It also paid over £8,000 to Mr S's estate to recompense the Industrial Injuries Disablement Benefit he would have otherwise received.

We recommended that the Trust produce an action plan as evidence that it will make sure a delayed diagnosis will not happen again. We also recommended that the Trust shares information about its failures with relevant staff across the Trust, and keeps patients fully informed about their condition and treatment.

Organisation(s) we investigated

Stockport NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 969/June 2015

Dentist removed wrong tooth

Periodontist indicated the wrong tooth when he referred patient to dentist. The dentist did not check, and removed another tooth.

What happened

Ms P's had been seeing a periodontist, a dentist who specialises in treating gum disease. The periodontist referred Ms P to the dentist as she needed to have a tooth extracted. The periodontist wrote to the dentist to ask for UR7 (upper right seven) to be extracted. When the dentist saw Ms P, she saw that UR7 was missing but UR6 and UR8 were both in a poor condition. She examined Ms P's teeth and took out UR8 as it appeared to be worse than UR6.

Two months later, Ms P visited the periodontist and he said that the dentist had taken out the wrong tooth. Ms P developed an infection under UR6 and so she went back to the dentist who took it out. Ms P said that the second extraction was complicated because the tooth had also broken, and she found the procedure stressful.

Ms P was unhappy as she said the dentist had removed the wrong tooth the first time, and that led to a delay in treating UR6 which caused her to suffer an infection.

What we found

We partly upheld this complaint. The dentist was right to say that UR7 was not present but she should have checked this with the periodontist rather than deciding for herself which tooth to extract. However, we found that both UR8 and UR6 had a poor long-term prognosis, and it was likely that Ms P would have gone on to have problems with UR8 if the dentist had not taken it out.

Putting it right

The Practice apologised to Ms P and the dentist acknowledged that she could have sought clarification before carrying out the extraction on UR8.

Organisation(s) we investigated

A dental practice

Location

Kent

Region

South East

Summary 970/June 2015

Psychiatrist followed the required standards

Mr D complained that a report written by his psychiatrist distorted the facts.

What happened

Mr D's GP referred him to a psychiatrist for a report so that he could understand how to manage any future deterioration in Mr D's mental health.

The psychiatrist carried out a full examination and review of Mr D's history. She produced a report and sent it to the GP. Mr D was unhappy that there were factual inaccuracies in the report and opinions that he disagreed with. The psychiatrist acknowledged that she had made some errors of fact and revised the report. She noted that Mr D disagreed with some of her opinions and added a statement to his records to show his disagreement with what she had said.

Mr D complained that this did not go far enough. He said the report showed him to be a criminal, rather than focusing on his documented mental health problems. He said the report almost led to him being sent to prison.

What we found

We did not uphold the complaint. The psychiatrist followed the relevant standards. She carried out an appropriate assessment and relied on records from Mr D's medical file. When some of these were shown to contain errors she acted appropriately by amending her report. She also acted appropriately when she agreed to add a record of Mr D's disagreement with her opinions to his file.

Organisation(s) we investigated

Avon and Wiltshire Mental Health Partnership NHS Trust

Location

Wiltshire

Region

South West

Summary 971/June 2015

Patient's jewellery and clothes went missing

Mrs P complained to us that the hospital said it was not liable for the loss of her property and refused to reimburse her for the cost.

What happened

Mrs P went to A&E with a facial injury. She had already taken her clothes off for an examination and then went to the X-ray department, where staff told her to remove her jewellery. She was transferred to another hospital later that day, wearing her hospital gown, but found that her property had not been sent with her.

Mrs P's family complained to the Hospital. The Hospital said that the nurse to whom Mrs P gave her jewellery was adamant that he had passed the jewellery to Mrs P's husband. Mrs P's husband was sure that when he went back to the Hospital to ask where the items were, the nurse told him he had put the jewellery in a bag with Mrs P's clothes.

What we found

We partly upheld this complaint. There were conflicting accounts of what happened, and the only agreement was that Mrs P had given the nurse the jewellery after she had taken it off. There were no records of what happened to the jewellery or clothes.

While the Hospital had an overall policy that it did not assume liability for items brought to the hospital, part of the policy said that staff must take a record on occasions where 'articles of value' are not handed in for safe keeping (in the Trust's general office or the night safe). The Hospital did acknowledge that Mrs P gave the jewellery to the nurse, but there was no record to confirm it was not handed in for safe keeping. So we concluded the Hospital was liable for the loss of the jewellery. We did not find the Hospital liable for the loss of the clothes as they were not classed as 'articles of value' and therefore we would not have expected the Hospital to have recorded them.

Putting it right

The Hospital accepted our recommendations and reimbursed Mrs P £570 for the value of her jewellery and also apologised to her.

Organisation(s) we investigated

Sherwood Forest Hospitals NHS Foundation Trust

Location

Nottinghamshire

Region

East Midlands

Summary 972/June 2015

Trust staff were rude to a vulnerable patient and his mother

Miss G complained that Trust staff were rude to her and her son on a number of occasions, that her son was not given adequate care, and a nurse tried to give him insulin when her son was not a diabetic.

What happened

Miss G complained that during a hospital stay staff did not give her son, who had learning difficulties and complex medical needs, adequate care, and so she had to provide this care herself.

She said some staff members were rude to her, and some were verbally abusive which caused her distress. She believed there was one occasion where a nurse tried to give her son an injection of insulin when he did not require it, and she thought that if this had happened, he would have died.

She also complained that staff should not have admitted her son to the ward because he was vulnerable, and it exposed him to inappropriate people.

She said staff prevented her from taking him out of the ward to get some fresh air. Finally she complained that she was not allowed to sleep by his bedside, and she was made to sleep in a storage room.

The Trust investigated Miss G's complaints before she brought them to us. It accepted that staff had been abusive and rude to Miss G on a number of occasions and apologised for this. It also accepted that some of the care it had provided was not to the standards Miss G expected, and apologised for this. The Trust advised Miss G that the room she slept in was a day room and that it could not allow her to sleep on the ward because it had a single sex policy. The Trust concluded that it had found no evidence that a nurse had tried to give her son insulin, and said that it prevented Miss G leaving the ward because she had threatened to take her son home and he was too unwell at that stage for his treatment to be stopped.

Miss G brought her complaint to us because she disputed some of the conclusions to the Trust's investigations. She did not think that it had gone far enough to put things right.

What we found

We did not uphold this complaint. There were times when the Trust did not provide adequate care, but generally the standard of care was appropriate. There was no evidence to suggest that the insulin incident occurred, and the ward in question was the most appropriate ward for her son as it provided the specialist care he required. But staff members had been rude and abusive to Miss G and her son.

Staff correctly prevented Miss G from leaving the ward until they knew she was not going to take her son home. The room she slept in was a day room with some storage in it, but this was the only place available for her to stay.

The Trust had already apologised to Miss G, and apologised to her again. It also gave her personal letters of apology from individual staff members. It held resolution meetings with her, and tried to agree solutions that suited all parties for her son's future care, and to make sure similar failings did not reoccur.

The Trust also increased its staffing levels on the ward and gave staff further training about attitude. We concluded that the Trust had adequately remedied the complaint and no further action was necessary.

Organisation(s) we investigated

Walsall Healthcare NHS Trust

Location

Walsall

Region

West Midlands

Summary 973/June 2015

Patient left alone fainted and injured herself

Ms F fainted after a vaccination and broke her nose, but it was not the hospital's fault.

What happened

Ms F went to the occupational health department at the hospital for a vaccination. After the vaccination she felt lightheaded and the nurse advised her to sit with her head between her knees. The nurse left the room to fetch her a glass of water, and while she was out of the room Ms F fainted and fell to the floor. An occupational health doctor examined her and advised her that she did not need immediate medical treatment, but should go to her GP if she felt worse.

Ms F later went to A&E and was diagnosed with a broken nose and concussion. She needed two operations to reconstruct her nose. Ms F complained about the treatment she received and how the Trust handled her complaint.

What we found

We did not uphold this case. The nurse acted appropriately in advising Ms F to sit with her head between her knees. However, the nurse should not have left Ms F alone and should have asked a colleague for help if she needed a glass of water. We found that the doctor carried out an appropriate examination and gave appropriate advice about head injuries to Ms F. Ms F did not have symptoms to indicate she needed immediate hospital treatment and therefore it was reasonable that she was not referred to hospital.

We could not link the nurse's actions with Ms F's broken nose, as even if the nurse was present it is still likely that Ms F would have fainted and fallen to the ground. The nurse would not necessarily have been able to prevent Ms F's injuries. The hospital had already apologised to Ms F and acknowledged its failings. Even though the Trust did not diagnose Ms F's broken nose at the time of the fall, and this was only diagnosed when she went to A&E, this was not a failing because the diagnosis is usually made a few days after the swelling has eased and when doctors can do an accurate examination. Immediate X-rays are not usually helpful in the diagnosis of a broken nose.

Organisation(s) we investigated

Dartford and Gravesham NHS Trust

Location

Kent

Region

South East

Summary 974/June 2015

District Nursing Service apologised for handling complaint poorly

Mr B complained about the treatment the Trust provided for his aunt and also about the way it handled his complaint.

What happened

Mrs R's GP referred her to the District Nurse Service for treatment of leg wounds. The district nurses regularly visited her but she developed a life threatening infection from her wounds, which led to a long hospital admission. She was unable to return to her previous level of independence and moved into a nursing home. Her nephew, Mr B, believed that the infection could have been avoided if the nurses had cared for her differently.

Mr B also complained that the Trust took seven months to respond to his complaint, and the response inaccurately said that his aunt had not been taking her antibiotics.

What we found

There were no failings in the care the district nurses gave Mrs R. However, the Trust handled Mr B's complaint about this poorly; its response took too long, and the first response contained an inaccurate statement. However, we did not uphold the complaint because the Trust had already apologised for the failings, explained the administrative error that led to the delay, and retracted the inaccurate statement about Mrs R. We considered that the Trust had already done all that we would expect to resolve this complaint.

Organisation(s) we investigated

Croydon Health Services NHS Trust

Location

Greater London

Region

London

Summary 975/June 2015

Patient disputed her diagnosis and highlighted administrative errors

Mrs J complained about the care and treatment she received at the Trust between 2006 and 2013. She said she did not agree with her diagnosis and doctors did not discuss this with her at the time. She said there were family history errors in her medical records, the Trust had lost some of her records, and she was dissatisfied with how it investigated her complaint.

What happened

Mrs J was diagnosed with a personality disorder in 2006, but had attended the Trust since 1999 with similar health problems. She complained to the Trust about how doctors made their diagnosis about her condition, and also errors in her medical records. She later complained that information about her complaint had been uploaded into her medical records, and that when she asked for copies of her file she found that records relating to three different episodes of care were missing.

What we found

We did not uphold this complaint. Psychiatrists at the Trust followed the relevant standards in how they assessed Mrs J and made their diagnosis. We also found evidence that they communicated this to Mrs J at the time.

Mrs J said there were entries in her medical records which made allegations about family members and she wanted these to be removed, but we found that these records showed that Mrs J had made the allegations. The Trust handled her complaint appropriately by allowing her to include a statement in her records setting out the issues that she disputed.

The Trust should not have uploaded Mrs J's complaint or lost her records. But we were satisfied that the Trust had already apologised for these errors and taken sufficient action to show what it had learned from the complaint. There were failings in handling her complaint, but we were satisfied that the Trust had already responded appropriately to these concerns.

Organisation(s) we investigated

Devon Partnership NHS Trust

Location

Devon

Region

South West

Summary 976/June 2015

Poor cancer treatment did not lead to patient's death

Dr L complained about his late wife's care between 2007 and 2008. He said the Trust failed to diagnose and treat her, delayed her treatment, failed to give her chemotherapy, discharged her inappropriately, and handled his complaint poorly.

What happened

The Trust treated Mrs L for a bowel obstruction in spring 2007 and found she had bowel cancer. She developed other medical problems and the cancer spread throughout her body. Mrs L died in summer 2008.

Dr L complained to the Trust in spring 2010 about various aspects of his wife's treatment. The Trust responded in early 2011 having spoken to 13 medical staff. Dr L submitted a follow-up complaint and met with the Trust. It provided a second and final response in early 2012.

Dr L then wanted an independent opinion on his complaint as he said he had no faith in the Trust and believed the treatment it provided had led to his wife's death. The Trust referred Dr L to the NHS Litigation Authority (NHS LA) as Dr L implied that he may take legal action. The NHS LA obtained a medico-legal opinion and Dr L commissioned his own medico-legal report. Dr L was dissatisfied with the NHS LA's report and so he came to us.

What we found

We partly upheld this case. There were no failings in some aspects of Mrs L's treatment. However, we did find the following failings by the Trust: a lack of supervision after her operation which contributed to a delay in treating a leak where sections of her colon had been re-joined; doctors should have carried out a biopsy on her sternum (breastbone) rather than on her vertebra; failure to respond to Mrs L's kidney problems; poor communication about chemotherapy treatment; two incorrect discharges; poor record keeping; and a delay in handling Dr L's complaints.

As a consequence of these failings, the Trust caused Dr L and Mrs L distress, as they could have chosen palliative care for her and been better prepared for her death. Poor record keeping also meant that we could not respond to parts of Dr L's complaint.

However, in our view Mrs L's death was not preventable. With the benefit of hindsight, it is likely that she had incurable disease at the time of her initial operation in spring 2007. The type and stage of her bowel cancer carries an extremely poor prognosis. Taking this into consideration we did not think that the Trust's failings had led to Mrs L's death, or that her life would have been prolonged had her care been better.

The NHS LA should have handled Dr L's case better and updated him more regularly.

Putting it right

The Trust accepted our recommendations and apologised to Dr L for the failings we identified. It also paid Dr L £3,200 for the distress this caused him and for the poor handling of his complaint.

The NHS LA apologised to Dr L for the delays in handling his case.

Organisation(s) we investigated

Maidstone and Tunbridge Wells NHS Trust

NHS Litigation Authority (NHS LA)

Location

Kent

Region

South East

Parliamentary and Health Service Ombudsman

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