Parliamentary and Health Service Ombudsman

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

October to December 2015

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and Health Service
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Introduction

The Parliamentary and Health Service Ombudsman investigates complaints about government departments and other public organisations and the NHS in England. This report is the ninth 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.

October 2016

Complaints about UK government departments and other UK public organisations

Summary 1106/October 2015

Replanting wood caused unforeseen problems

When Mr C wanted to replant his wood, he found the government policy, guidelines and regulations for doing this had changed, and he could not replant the same tree species as he had originally wanted.

What happened

Mr C owned a farm in a National Park. Part of his farm was an enclosed wood. In 2007 he decided to chop the wood down for timber. To do this he needed a licence from the Forestry Commission (the Commission). The licence also set out how he should replant the wood afterwards. When Mr C applied for his licence, he wanted to replant his wood with the same tree species that was there before. However, the application had to go through a public consultation process, and when it did, the National Park objected to Mr C's proposals. It said the shape of the area to be replanted and the original tree species required careful consideration and were not acceptable in such a sensitive location.

Mr C met the Commission and the National Park to try and resolve this problem. After discussions, Mr C agreed to change his proposals and plant broad-leaved trees in the wood. He did so in exchange for a payment of £6,000 from the National Park, which covered the increased costs of planting those trees. Mr C also applied for a grant from the Commission to help plant his wood.

By 2011 Mr C found many of the trees in his wood had died or failed to thrive because they were not suited to the site conditions. Mr C therefore complained to the Commission about the situation. He argued the Commission had forced him to accept an unsuitable replanting plan that he did not want to follow and that was doomed to fail.

Mr C asked the Commission to approve a new replanting plan, which was in his original application. The Commission refused to do this, but it helped Mr C to design a compromise solution for his wood. It also told him how to apply for a different grant to help regenerate his wood.

Once the Commission agreed a new application, Mr C found some contractors to replant his wood but their costs were greater than the grant the Commission was offering. Mr C therefore did not proceed with his application and instead, complained to his MP.

Mr C's MP suggested that the Commission clear the wood with its own contractors and machinery. The Commission refused to do this, and Mr C therefore complained to us. He said the Commission gave undue weight to the wishes of the National Park over his, as the owner of the wood. The Commission did not scrutinise the National Park's advice about which trees should be replanted in the wood. Mr C said many of the trees in the wood had died as a result of this, and he had lost five years of growth on it. He also said he suffered a financial loss of over £7,000, his land had reduced in value, and it was now an eyesore.

What we found

We partly upheld Mr C's complaint. Government policy for managing woodland is set out in the UK Forestry Standard. This confirms what type of trees can be planted in a particular wood, and the proportions of each species. The Commission is responsible for making sure landowners comply with the the UK Forestry Standard. It is encouraged to do this by agreement rather than by enforcement.

The Commission's records dating back to Mr C's original application in 2007 were very sparse, and this contributed to a lot of the confusion that surrounded this case. We criticised the Commission for the confusion and inconvenience it had caused to Mr C. We asked the Commission to apologise to him to put these failings right.

We found that when Mr C applied to chop his wood down and replant it, his original replanting plan did not meet the UK Forestry Standard. As the National Park was also opposed to the plan, the Commission tried to come to an agreement with Mr C about his wood. It thought it had done this when Mr C agreed to plant what the National Park suggested in return for a payment. We found the Commission acted in good faith and it was reasonable for it to accept what it was told by all parties in the consultation.

However, we found the Commission failed to scrutinise the mix of tree species in Mr C's replanting plan, but it was not solely to blame for the failure of the wood. It had apologised to Mr C for its failure to scrutinise and had also decided it would not take action to recover Mr C's original grant from him (as it was entitled to do). We found these were suitable actions to put right what had gone wrong.

Putting it right

The Commission apologised to Mr C for the inconvenience and frustration its poor record keeping had caused him.

Organisation(s) we investigated

Forestry Commission

Summary 1107/October 2015

Failure to communicate changes in law about backdating Disability Living Allowance

Mr N complained that the Independent Case Examiner (ICE) did not deal properly with his complaints about how Jobcentre Plus and the Disability and Carers Service had handled his benefit claims. He said he suffered financial loss and damage to his mental health as a result of Jobcentre Plus's actions.

What happened

In autumn 2012 Mr N claimed Employment and Support Allowance (ESA) from Jobcentre Plus to top up his student loan income. Two months later, Mr N complained to Jobcentre Plus about the delay in deciding his claim. Jobcentre Plus apologised and when it processed Mr N's claim, it refused it on the basis that he had too much income from his partner's benefits and from his student grant and loan to qualify for ESA. Mr N appealed against that decision and 12 weeks later, having reconsidered its decision, Jobcentre Plus refused to change it and forwarded Mr N's appeal to HM Courts & Tribunals Service (HMCTS) for action.

Around the same time Mr N renewed his claim for Disability Living Allowance from the Disability and Carers Service. Mr N was already receiving benefit but was seeking a higher rate because his mental health had deteriorated and he needed more care. At the beginning of 2013, the Disability and Carers Service gave Mr N the same lower rate of benefit he had received previously. Mr N appealed against that decision and asked the Disability and Carers Service to backdate any increase to his benefit.

The Disability and Carers Service forwarded that information to HMCTS. In spring 2013 Mr N gave fresh evidence to the Disability and Carers Service about his ill health. It looked at that evidence, but decided it did not affect the decision, and sent it on to HMCTS to consider as part of the appeal.

Mr N complained to Jobcentre Plus and the Disability and Carers Service about the service he had received from them. Disappointed with their responses, Mr N complained to ICE. ICE concluded that although there were delays in Jobcentre Plus processing Mr N's ESA claim, they were not so serious as to amount to service failures. However, it concluded that the Disability and Carers Service should have explained to Mr N to take up his request for backdating his Disability and Living Allowance with HMCTS sooner than it did. It also concluded that the Disability and Carers Service had not responded to Mr N's complaints promptly and that he should be paid £125 for the inconvenience and distress the delay had caused. Mr N remained unhappy with ICE's decision and complained to us.

What we found

We did not uphold the complaint about Jobcentre Plus. We partly upheld the complaint about the Disability and Carers Service and ICE.

We found that ICE had reached reasonable conclusions on all but one aspect of Mr N's complaint. It overlooked the fact that the Disability and Carers Service should have told Mr N that the law did not allow it to backdate Disability Living Allowance, rather than tell him to contact HMCTS.

Putting it right

The Disability and Carers Service apologised to Mr N for not telling him that Disability Living Allowance could not be backdated because of a change in law and paid him an extra £50 to recognise the inconvenience of pursuing this aspect of his complaint.

Organisation(s) we investigated

Jobcentre Plus

Disability and Carers Service

Independent Case Examiner (ICE)

Summary 1108/October 2015

HMCTS apologised for unnecessary bailiff visit

A mistake by court staff led to Mr D getting a visit from a bailiff, causing distress for all involved.

What happened

HM Courts & Tribunals Service (HMCTS) convicted Mr D of a driving offence in his absence. He later went to court to get the conviction overturned. HMCTS told the Driver and Vehicle Licensing Agency (DVLA) to remove any record of the conviction because it was no longer outstanding. But unfortunately no note of this was made on the court register and the enforcement records still showed a fine outstanding and the conviction in place. As a result, HMCTS issued a distress warrant (a licence authorising the seizure of his property for money owed) and a few months later a bailiff visited Mr D at home in the house owned by his fiancée's mother.

The bailiff took a record of some items and when he tried to enter Mr D's bedroom, Mr D asked him to leave. The bailiff later returned to the property with two police officers to take a record of other items in the remaining rooms. During this second visit there was an altercation and members of Mr D's family were arrested for assaulting the bailiff.

When Mr D complained to HMCTS, it apologised and eventually offered him £250 compensation. HMCTS also said that it would seek to improve its record keeping to prevent the same mistake happening again. Mr D complained to us because he considered that £250 was not enough in light of all that happened.

What we found

We did not uphold this complaint. We found that HMCTS' poor record keeping led to an alarming bailiff visit. However, there was no evidence of what happened during the visit. It was clear that the actions of individuals at the property were key to the way the matter escalated. But we could not make findings about why the matter snowballed in the way that it did. Because of this, we could not find that HMCTS was directly responsible for all of the distress that Mr D experienced. After careful consideration we decided that HMCTS' offer of £250 was suitable in the circumstances.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 1109/October 2015

UKVI's poor communication affected transparency

Mr K complained that UKVI refused to review its decision to refuse his European Economic Area (EEA) application for permanent residence, wrongly told him that he had to leave the UK, and lost his ID card. Mr K was also unhappy with UKVI's handling of his complaint.

What happened

Mr K arrived in the UK in autumn 2008 and had lived in the UK since. In autumn 2013 Mr K applied for an EEA permanent residence card. He included his ID card with the supporting documentation.

Two months later, Mr K asked UKVI to return his ID card so that he could visit a sick relative outside the UK. Mr K said that he submitted a Return of Document (ROD) request to UKVI but there was no record of that in his or UKVI's records. UKVI recorded that Mr K had contacted it a number of times about his request, but told him it was not on the system.

In early 2014 UKVI refused Mr K's application on the basis that he could not show employment for the first four months of his residence in the UK from autumn 2008, plus he had claimed Jobseeker's Allowance for the following six months, which he was not entitled to do. UKVI gave Mr K the right to appeal its decision. Its letter noted that Mr K's ID card was included in the returned documentation. However, a few days later Mr K complained to UKVI about its decision to refuse his application and asked it to reconsider that decision. He also told UKVI that it had lost his ID card.

UKVI said that it could not 're-access' Mr K's application and that he could have appealed its decision,noting however, the time limit for an appeal had lapsed. UKVI said that there were no grounds to reconsider Mr K's application. It thought that Mr K's ID card had become separated while in transit to him and urged him to contact Royal Mail about it. UKVI said that Royal Mail records showed that the package had been signed for.

Mr K felt that UKVI discriminated against him. Mr K wanted an apology, his residence card (which UKVI has since granted) to be backdated to his first application and for a consolatory payment.

What we found

We partly upheld Mr K's complaint. UKVI's response to Mr K that it could not re-access his application was not strictly true because its policy allowed it to reconsider decisions that might be successfully challenged at appeal. We found that UKVI gave Mr K the impression that it had not reviewed its decision, when actually it had and it thought there were no grounds to reconsider the case. UKVI's communication with Mr K should have been clearer on this point. However, we found that UKVI's actions did not prevent Mr K from appealing the decision if he felt it was wrong.

In relation to Mr K's ROD request, we found that whilst there was no record of him having made it in late 2013, it would have been reasonable for UKVI to have actioned his request following his telephone calls later in 2013 and early 2014. But, as Mr K's case was decided in early 2014, we found that any delay as a result of UKVI's actions was only a few days after his phone calls.

We found that there was no persuasive evidence that allowed us to make a finding as to how Mr K's ID card was lost. We did not find that the loss was as a result of UKVI's actions.

We did not find evidence that Mr K was told that he had to leave the UK. We noted that UKVI had lost some records of the telephone calls, which we recognised was particularly frustrating for Mr K. However, we noted that UKVI's decision letter in early 2014 made it clear that Mr K was not required to leave the UK.

We carefully considered Mr K's allegation of discrimination by UKVI but found no evidence of that in the records available, even though some records were missing.

Putting it right

UKVI apologised to Mr K for the inconvenience and distress its handling of his request caused, the loss of the telephone records and its communication with him about his reconsideration request.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 1110/October 2015

UKVI's poor communication led to a 12-month delay to process application

UKVI took a long time to make a decision on Mr T's application for nationality. It also did not properly update him about when he would receive a decision.

What happened

In spring 2014 Mr T made an application for British nationality. In summer 2014 UKVI initially wrote to him informing him that his application had been successful and it would write to him inviting him to a citizenship ceremony. However, following his contact with UKVI to chase the matter, UKVI told Mr T that it had identified further checks it needed to make to ensure all the citizenship requirements were met.

Mr T contacted UKVI on numerous occasions asking for an update but was told that the application was ongoing. He was also repeatedly told that checks were being carried out.

In spring 2015 UKVI wrote to Mr T refusing his application. It explained that, following his conviction and prison sentence in 2005, he did not meet the 'good character' requirement. It said it had not been ten years since the prison sentence had finished, which was a requirement of its guidance.

UKVI also refused Mr T's request for a reconsideration of his application in spring 2015.

Mr T complained that UKVI took a long time to assess his nationality application and about its refusal to reconsider its decision.

He said UKVI acted unfairly and refused to recognise that he did not have a criminal conviction and had only been imprisoned because of an immigration issue relating to his change of name. As a result of UKVI's actions, Mr T said that he was unable to travel and that he felt unsettled. He sought a refund of his application fee from UKVI.

What we found

We partly upheld this complaint. We found that the Independent Chief Inspector of Borders and Immigration (the ICI) had warned the Home Office in summer 2014 that it may need to review its policy position on good character requirements in relation to applications for British citizenship. This was before the ICI issued his report in late 2014. In summer 2014, if someone had been given a prison sentence of up to 12 months, they would not qualify for British citizenship for seven years. However, we noted that following the formal publication of the ICI's report in late 2014, UKVI had increased the amount of time that needed to have passed following the end of the prison sentence to ten years.

We found it was reasonable for UKVI to consider the impact of the ICI's warning from summer 2014, which may have affected Mr T's case and that UKVI was entitled to refuse Mr T's application. Mr T told us that he had been imprisoned in 2005 for using a false name but that this was not a criminal conviction, which was why he ticked the box on the form saying he did not have a criminal conviction. However, UKVI shared with us court papers that confirmed Mr T had a criminal conviction in 2005.

We found that UKVI's consideration of Mr T's application would not have affected his ability to travel.

In relation to UKVI's handling of the application, we found that it did not provide accurate updates to Mr T. UKVI said it was undertaking further checks when it was doing no such thing. Instead UKVI was reviewing its requirements for nationality applications during that time. We also found that if UKVI had communicated better and decided Mr T's application more quickly, it might have prevented the emotional distress that he suffered.

Putting it right

UKVI apologised for its poor communication and incorrect updates in handling Mr T's application. It also paid Mr T £100 in recognition of the distress caused.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 1111/October 2015

County court bailiff overlooked goods when seeking to recover debt

A bailiff visited a business premises to recover a debt. However, he missed the opportunity to take control of equipment inside of the shop and a van that was parked outside, and went on to give Mr P inaccurate information about the visit.

What happened

Mr P successfully obtained a court order requiring a business to pay him over £4,600 for outstanding debts. Mr P then applied to pursue recovery of this debt through county court bailiffs.

When the bailiff visited the business premises it was locked and abandoned. The bailiffs returned the paperwork to Mr P stating that there was no sign of the owner and 'no saleable goods' in the shop. Therefore, no further action could be taken unless Mr P reapplied and gave the bailiffs further information.

Mr P's wife visited the shop and saw that there was still equipment inside and a business van parked outside. There was also a sign on the window with contact details for the shop's landlord. Mr P complained to the bailiffs that there clearly were saleable goods on site.

Mr P reapplied to the bailiffs, but a few days later the shop's landlord emptied the shop and removed the vehicle. Mr P complained that the bailiffs had missed an opportunity to recover the money he was owed. HMCTS admitted that the information on the paperwork was incorrect, but it said the outcome would not have been any different as the bailiff could not enter the shop because it was locked.

The bailiff could not recall seeing a vehicle or a sign with contact details for the landlord.

Mr P said he was left out of pocket and wanted HMCTS to pay the full value of the outstanding debt and also award him a payment for the poor service he received.

What we found

We partly upheld Mr P's complaint. During our investigation we contacted the shop's landlord who confirmed that he had the keys to the vehicle and it had been parked outside the premises at the time of the bailiff's visit. He also said he had placed a sign in the shop window with his contact details, which would also have been there at the same time. We considered the shop's landlord to be an independent witness and found that it was very likely that both the sign and the vehicle had been at the premises during the bailiff's visit.

However, we concluded that even if the bailiff had made further enquiries about the goods and vehicle, it was highly unlikely to have led to the recovery of the debt. The van was on a finance plan and therefore could not have been taken by the bailiffs. It was likely that the bailiff would also have had difficulties taking goods from the shop as this would have been complicated by the fact that residential accommodation was also attached. Finally, the equipment in the shop was likely to have had a low resale value and may not have been worth the costs involved to remove them.

We found that Mr P was given incorrect information that there were 'no saleable goods' and this had caused him great frustration because he believed the bailiff had missed the chance to recover his debt. HMCTS had also handled his complaint poorly at times.

Overall, we found that it was unlikely that the bailiff would have recovered the debt even if he had made further enquiries. As such, we saw no grounds to recommend that Mr P was reimbursed for the value of the debt. However, Mr P had suffered a significant level of frustration because the bailiff had not tried to find out if he could have taken control of the vehicle and because he had been given inaccurate information.

Putting it right

HMCTS apologised to Mr P and paid him £250 in recognition of the frustration caused to him.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 1112/October 2015

Poor complaint handling added to an already stressful situation

Mrs F was unhappy at the Care Quality Commission's (CQC's) apparent failure to safeguard her husband following his admission to, and subsequent removal from a care home. She also complained about the CQC's poor complaint handling about this.

What happened

There were two aspects to this complaint; the CQC's failure to carry out its safeguarding responsibilities appropriately and its handling of Mrs F's complaint about this.

The CQC inspected a care home and, although it was satisfied with the overall quality of care given, it found one of the rooms was in poor condition. The care home had already recognised this and had plans in place to improve the room. As a result the CQC took no further action other than to recommend that the care home continue with those improvements.

Shortly after the inspection Mrs F's husband was admitted to the care home and allocated to the room. However, the planned improvements had not yet taken place. The care home apologised to Mrs F and offered to move her husband to an alternative room once one became available. However, Mrs F removed her husband from the care home. A few days later Mrs F's husband died after a fall at his own home.

Mrs F complained to the care home about its decision to allocate an unfit room. She also complained to the CQC about its failure to take effective action to safeguard her husband. She said the CQC should have done more to ensure that the care home had provided a safe level of care to her husband.

She also complained that the CQC should have taken regulatory action against the care home once it became aware of what had happened. The CQC responded and said it had acted appropriately and within the relevant guidelines.

Mrs F remained dissatisfied with the CQC's response and was also unhappy with the CQC's handling of her complaint about this. Mrs F said the CQC repeatedly failed to respond to letters sent via recorded delivery to it, lost documents and generally poorly managed her contact with it. She asked us to investigate whether the CQC acted appropriately following the raising of safeguarding concerns with it, for CQC's records to be amended to accurately reflect events, and a sincere apology from CQC for the distress and anguish caused to her.

What we found

We partly upheld this complaint. We did not uphold Mrs F's complaint about the CQC's failure to carry out its safeguarding responsibilities appropriately. Although the CQC's inspection had found the room to be in a poor condition, it had not found it was so poor it could not be used. It had also taken appropriate action to make sure the care home improve the condition of the room by a set deadline.

In addition, the CQC could not reasonably have known that, following the inspection, the care home would allocate the room to Mrs F's husband. The CQC had responded appropriately to safeguarding concerns that had been raised about Mr F's well-being, both after his removal from the home and following his death. This included taking part in multi-agency reviews to look at what had happened (the reviews found the care home had not been responsible for Mr F's death).

However, we found that the CQC's handling of Mrs F's complaint had been poor. The CQC failed to respond properly to Mrs F's complaints about this incident. It had failed to keep appropriate records of events that made it difficult for it to respond properly to Mrs F's concerns. The CQC also failed to pay adequate attention to the records it had, leading to some of its responses being inaccurate and/or misleading. As well as this, it failed to deal properly with some of the correspondence Mrs F sent to it.

Putting it right

The CQC apologised to Mrs F for its poor handling of her complaint. It also paid her £250 in respect of the inconvenience and upset she suffered as a result.

In addition, the CQC drew up an action plan to show what it had done to improve handling of incoming correspondence, which had been a contributory factor in its failure to deal properly with Mrs F's complaint. It also issued guidance to its staff on how to handle and record information.

Organisation(s) we investigated

Care Quality Commission (CQC)

Summary 1113/November 2015

Courts sent papers to the wrong address so bailiffs' arrival was a shock

Ms N did not receive notices from HM Courts & Tribunals Service (HMCTS) telling her that it would take further action over a court fine.

What happened

In summer 2013 Ms N told HMCTS that she was moving, but it did not update her new address on its records. Later, HMCTS sent her notices about a court fine she had to pay, and of the further action it could take if she did not pay the fine. But the letters went to her old address and so she did not receive them. Ms N was therefore shocked when she received a call from the bailiffs saying they were outside her old address. The bailiffs asked for her new address and went there at a later date. Mrs N had to spend time and money writing to the bailiffs and to HMCTS to try to resolve the matter.

What we found

HMCTS failed to update Ms N's address, which meant she did not receive notices about her court fine or any action it may take if she didn't pay the fine. Because of this, Ms N did not have the opportunity to prevent the matter escalating and the bailiffs arriving at her old home. We could not say whether she would have been able to prevent the matter being passed to the bailiffs, but had she received the notices she would at least have known the matter was accelerating and had time to plan for this.

HMCTS handled Ms N's complaint poorly. It should have realised that Ms N had not received the notices about her fine, and arranged for the case to be returned to it from the bailiffs. Instead Ms N was left to argue the matter with the bailiffs herself.

Putting it right

HMCTS apologised to Ms N for its failure to update her address and for the subsequent injustice this caused her. It paid her a total of £400 for not resolving the matter earlier and for its poor complaint handling. This was also to cover the time and money Ms N spent corresponding with HMCTS and the bailiffs. HMCTS agreed to look into why it had not updated Ms N's address details in summer 2013 and to review its procedure so that the same thing would not happen again.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 1114/November 2015

Border Force mishandled compensation claim

Border Force confused Mr A's records with another person, refused him entry into the UK, and mishandled his claim for compensation.

What happened

Mr A lived and worked in the UK and flew to his home country in early summer 2013 to visit relatives. When he came back, Border Force confused his records with another person, refused him entry to the UK and sent him back to his home country.

Mr A returned to the UK a couple of weeks later and was allowed into the country this time. However, by then his work in the building trade had been given to another sub-contractor and Mr A lost his job. He was out of work for months and started to suffer from depression and anxiety because he could not provide for himself and his family.

Mr A complained to Border Force and claimed compensation. Border Force admitted its mistake and offered to compensate Mr A for the cost of the additional flights he had taken, and pay him £500 for the inconvenience he had experienced. It did not offer any amount for Mr A's loss of earnings or his related depression despite him providing Border Force with proof of his illness.

What we found

Border Force wrongly considered Mr A's claim for compensation. It should have known that because of his nationality he was only able to work in the UK on a self-employed basis. Therefore, it should have considered his loss of earnings under its exceptional circumstances rules, rather than refuse it outright.

Additionally, Border Force should have considered the effect on Mr A's mental health when it decided the amount of the consolatory payment.

When Mr A asked Border Force to reconsider his complaint, the same officer who had first decided the amount of compensation, overlooked her earlier error not to treat Mr A's case as exceptional, and confirmed the original offer was correct.

This meant that Border Force failed for a second time to properly consider Mr A's claim for his losses.

Putting it right

Border Force paid for Mr A's airfares as it said it would, and also paid him over £1,300 for his lost earnings. Although Border Force had not considered Mr A's claim for the effect on his mental health, we were satisfied that the £500 it originally offered him for inconvenience was appropriate.

Organisation(s) we investigated

Border Force

Summary 1115/November 2015

Legal Aid Agency's long delays

The Legal Aid Agency (LAA) delayed processing applications for legal aid and an appeal.

What happened

Mr S applied for legal aid. Shortly afterwards, he and his wife made further applications for legal aid in connection with three separate matters. LAA failed to process the further applications despite receiving enquiries on three separate occasions from Mr S's MP.

The LAA refused Mr S's original application, and he appealed that decision. However, the LAA took over a year to arrange that appeal.

Mr S said LAA's handling of his complaint was extremely poor and that it did not respond to or deal with his concerns appropriately. He said his health, wellbeing and finances were affected and he was not treated fairly.

What we found

The LAA unreasonably delayed both handling Mr S's appeal on his first application, and processing Mr and Mrs S's further applications.

Putting it right

The LAA apologised to Mr and Mrs S and paid them £500 in recognition of the injustice they had suffered. It also reviewed other applications for legal aid the couple had made (which were not covered by our investigation).

Organisation(s) we investigated

Legal Aid Agency (LAA)

Summary 1116/November 2015

Legal Aid Agency and Ministry of Justice failed to deal correctly with a request for information

Mr F wanted information about an investigation the Legal Aid Agency (LAA) carried out into the actions of his solicitors, but LAA refused this.

What happened

Mr F's solicitors were investigated by the LAA for legal aid fraud. The investigation concluded in 2014 and Mr F asked the LAA for information about the outcome of its investigation. The LAA refused this under the *Freedom of Information Act* (FOIA). The LAA is part of the Ministry of Justice (MoJ), which was also involved in Mr F's request. Both offices said that the personal data of others would be compromised if they disclosed the information Mr F wanted.

The LAA and the MoJ maintained their position, but did not explain to Mr F that he could appeal their decision by contacting the Information Commissioner's Office (ICO).

What we found

The LAA and the MoJ did not handle Mr F's request for information well. They were not clear why they refused to give him the information, or explain how their decision could be reviewed. This meant that Mr F was unnecessarily put to the inconvenience of complaining to us when they should have directed him to the ICO.

Putting it right

The LAA apologised to Mr F for its poor handling of his request for information. It also looked again at Mr F's request for information under the FOIA and directed him to the ICO so that it could review the LAA's decision.

Organisation(s) we investigated

Legal Aid Agency (LAA)

Ministry of Justice (MoJ)

Summary 1117/November 2015

UKVI gave applicant misleading information

UK Visas and Immigration (UKVI) did not tell Mr R about the options for renewing his visa, so it became out of date and he had to pay another fee of over £500 to have it renewed.

What happened

Mr R worked in the UK on a visa. Before his application was due to expire, he applied to renew it. But this category of visa no longer existed and UKVI told him that he had just two options: either withdraw his application or leave it to be considered and possibly refused. Mr R withdrew his application, which meant that when he applied for it again it was 'out of time' as his visa had expired by then. Because of this, UKVI refused his application. Mr R said he then had to return to his home country to make a new visa application from there and pay over £500 for it. That visa application was successful, but Mr R felt that because of UKVI's error he suffered stress and had lost his job.

What we found

We partly upheld this complaint. UKVI should have told Mr R of a third option he could use to renew his visa, to apply for it in another category. This option would have meant that he would not have had to pay an additional visa application fee of over £500, and his application would have remained 'in time'. Because of this Mr R suffered an injustice as he would never know if an 'in time' visa application would have been successful.

But we could not say that Mr R had to return to his home country because of UKVI's failings. This was because we could not say whether his visa application would have been successful even if it was 'in time'.

UKVI also handled Mr R's complaint poorly.

Putting it right

UKVI apologised to Mr R and refunded him the application fee of over £500. It also paid him £500 for the injustice he suffered as a result of never knowing how an 'in time' application would have been decided, and for UKVI's poor complaint handling.

Organisation(s) we investigated

UK Visas and Immigration (UKVI)

Summary 1118/November 2015

HMCTS made a number of errors in enforcing a warrant

Poor communication meant Mr C had to chase up HM Courts & Tribunals Service (HMCTS), and its electronic system created more problems.

What happened

Mr C made a successful county court claim against two tenants who owed him money for unpaid rent. He applied for a warrant of execution (a way of enforcing the court's judgment) against his tenants so that he could retrieve his money, using Money Claim Online (HMCTS's online service). There was a charge for the warrant. But the electronic system did not let him add the names of both the tenants. This meant that when a bailiff went to visit the first tenant, he spoke to the second tenant, but did not attempt to enforce the warrant because he did not realise that she was also a debtor.

When this came to light, HMCTS agreed to enforce the warrant again free of charge, so that Mr C would not have to pay for it again. But this did not happen without Mr C having to chase it up twice. Then when HMCTS re-issued the warrant there was a long delay because the bailiff was off sick. After Mr C chased up the matter, the bailiff visited the second tenant again and she arranged to make the payment.

Mr C complained to HMCTS and it apologised and offered him £100 compensation. But Mr C said that HMCTS's actions caused him a great deal of confusion and frustration when trying to get the matter sorted out. He came to us because he did not believe HMCTS had done enough to put things right and he wanted an independent review.

What we found

HMCTS made a number of errors in this case. Its communication was poor and Mr C was inconvenienced by having to chase matters up. Its electronic systems did not make it easy for creditors to chase up two defendants when they lived at the same address, and we recommended it sort this problem out.

Putting it right

HMCTS paid Mr C £200 and addressed the problems with its electronic systems so that applicants would not experience the same issues in the future.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 1119/November 2015

Typographical error causes confusion

The Information Commissioner's Office (ICO) made a typographical error in a letter it sent to Mr J's company which caused confusion.

What happened

Mr J runs a retail company. A customer complained to the ICO that he had received unwarranted marketing material from Mr J's company despite having no existing relationship with it.

The ICO wrote to Mr J saying his company was in breach of the relevant regulations on direct marketing and asked for the customer's details to be removed from the company's marketing lists.

Mr J responded with evidence that his company had had previous dealings with the customer, which, under the relevant regulations, meant the company was free to send the customer direct marketing material. However, the ICO said that, to be compliant with the regulations, each time Mr J's company contacted the customer it should have given the customer a facility to opt out of receiving further marketing correspondence. In this instance, the ICO had tested the opt-out facility Mr J's company had sent to the customer (an email link to an 'unsubscribe' function) and found it did not work.

Mr J complained to us that he had been unfairly criticised over the marketing material he sent to the customer, and the ICO had acted unreasonably. He said his company had been unjustly found guilty of a breach in regulations it did not commit, and this would have an effect on his company's reputation.

What we found

We partly upheld Mr J's complaint. The ICO had acted reasonably when it decided that Mr J's company had breached the relevant regulations. However, the ICO had made a typographical error in its initial letter to Mr J's company, which caused confusion about the action the ICO had taken.

The letter said that the company had breached the regulations, whereas it should have said, 'appeared to have breached the regulations'. This led Mr J to believe the ICO had made a final decision on the regulatory breach when it had not done so.

Putting it right

The ICO apologised to Mr J for any confusion its typographical error had caused.

Organisation(s) we investigated

Information Commissioner's Office (ICO)

Summary 1120/December 2015

RPA acknowledged failings but did not put things right

Mr R complained that the Rural Payments Agency (RPA) did not give him sufficient payment for incorrectly advising him that he was not eligible to claim for payments under the Single Payment Scheme (SPS) in 2005. He suffered financial losses of more than £60,000 over an eight-year period.

What happened

Mr R was a hill farmer and RPA was giving him Hill Farm Allowance payments before the SPS was introduced. When it was introduced in 2005, RPA sent Mr R an SPS booklet and claim form. He contacted RPA and was advised that he was not eligible to claim under the SPS. This meant that Mr R did not submit an application and did not establish entitlements, which were the basis for making future claims for payment under the SPS.

In 2006, Mr R complained to RPA about the advice he had received in 2005. But it was only in 2014 that RPA accepted that its incorrect advice had resulted in Mr R losing out on the chance to claim under the SPS for eight years. RPA said it would only pay Mr R for the years between 2005 and 2007. It said that from 2008, Mr R was aware that he could purchase entitlements on the open market in order to be able to make future claims under the SPS.

Mr R complained that he had not been in a good financial position in 2008 to be able to purchase entitlements. He said as a result of RPA's failings he had taken out loans '*just to keep his head above water*'. The money he should have received from RPA would have helped to stop him getting into so much debt.

What we found

We upheld this complaint. RPA had accepted that its failings in 2005 had resulted in Mr R losing the opportunity to make future claims for payments under the SPS, and it paid him for the years between 2005 and 2007. However, from 2008 onwards, RPA had not considered Mr R's financial situation properly, and it failed to put things right for him. We found that in 2008 Mr R's financial position had been so bad that he probably would not have been able to get any credit to allow him to purchase entitlements, so he could not make a decision about whether or not to purchase entitlements.

RPA's failure to pay Mr R for claims he could have made from 2008 onwards was a clear injustice. We found that this had a detrimental impact on the situation Mr R was in because he suffered a significant shortfall in income each year he was not receiving payments, which amounted to over £60,000.

Putting it right

RPA apologised to Mr R for the failings we identified in our investigation. It paid him for the claim values between 2008 and 2014, with appropriate interest. RPA also paid Mr R a consolatory payment of £3,000 to recognise the impact on him of not having received the SPS payments on time.

Organisation(s) we investigated

Rural Payments Agency (RPA)

Summary 1121/December 2015

Courts denied executor opportunity to dispute solicitor's costs

A series of failings at the Senior Courts Costs Office (SCCO) had serious implications for an estate, and caused distress and inconvenience to its executor.

What happened

Mr T was the sole executor of his late father's estate. The Court of Protection had appointed a firm of solicitors to act as deputy (they make decisions for someone who lacks capacity) for Mr T's father before he died. When Mr T's father died shortly after this, the solicitors sent the estate a bill, which Mr T felt was too high. Mr T paid some of the bill but the solicitors did not accept that Mr T had covered their costs and sought a detailed costs assessment from SCCO This assesses costs and expenses incurred in a dispute in order to decide how much a client should have to pay their solicitor.) SCCO carried out the assessment and issued a final costs certificate.

Mr T only became aware of this when he received the final costs certificate from the solicitors along with a demand for more money. Mr T challenged the solicitors and contacted SCCO to find out why he was not told about the assessment. SCCO then cancelled the final costs certificate and allowed Mr T to submit points of dispute. The solicitors firm was also invited to comment on Mr T's points. SCCO assessed all of that information and effectively agreed that the estate had already paid the solicitors' costs. Mr T did not hear further from SCCO for a few months, so he contacted it and asked whether the matter was closed.

SCCO told Mr T in an email that the solicitors would not be awarded further costs. He then began to wind-up his late father's estate in the belief that no further costs would be owed.

Over a year later Mr T received another final costs certificate from the solicitors for a reassessment he knew nothing about. This awarded the solicitors' firm further costs. Mr T contacted SCCO to find out what was happening. SCCO failed to respond to his enquiries, so he made a formal complaint to HM Courts & Tribunals Service (HMCTS), which administers the work of SCCO. HMCTS apologised for the delays and difficulties Mr T had experienced when dealing with SCCO. Mr T said an apology could not put matters right and he complained to us.

What we found

We upheld this complaint. We could not say whether it was right or wrong for the solicitors to receive further costs from the estate. SCCO's failings had left the estate in a position where it had effectively lost the opportunity to challenge the solicitors' costs. The apology that HMCTS had given did not put that right.

We found that SCCO had not followed its procedures when the first assessment was carried out. It then gave Mr T information that led him to believe the estate would not have to pay further costs. SCCO went against that assurance when it awarded further costs to the solicitors, and it did not give Mr T a chance to comment before making that decision.

In addition, we found the estate had overpaid tax because it was wound up on the expectation that no further costs would become due. We told Mr T that he should try to reclaim the tax, but in the event he could not do this, we said HMCTS should reimburse this money to the estate.

We found that Mr T had also encountered poor service throughout his dealings with SCCO. He also said the estate had paid legal costs unnecessarily because of HMCTS' failings.

Putting it right

HMCTS accepted our recommendation and paid the estate £500 for the loss of opportunity to challenge the detailed costs assessments. HMCTS also reimbursed the estate £580 for the legal costs paid unnecessarily. Finally, HMCTS paid Mr T £250 for the distress and inconvenience he was personally caused.

Organisation(s) we investigated

HM Courts & Tribunals Service (HMCTS)

Summary 1122/December 2015

Passport Office did not tell applicant that timescales for dealing with applications had changed

Mr D said HM Passport Office did not process his son's passport application properly or deal with all of his complaints.

What happened

In early spring 2014 Mr D's wife gave birth to their son while they were all living temporarily overseas. Around the same time, Mr D applied for his son's first British passport at the British Embassy overseas. HM Passport Office in the UK received that application and the supporting documents shortly after. A month later, after doing initial checks on the application, HM Passport Office transferred the application to the team specialising in dealing with applications from overseas. This team asked the British Embassy to carry out an evidence of identity interview with Mr and Mrs D.

The interview took place in late spring 2014. Three days after this HM Passport Office decided it was unable to approve issuing a British passport to Mr D's son because there was no proof the child was his. HM Passport Office suggested Mr D, his wife and son take a DNA test to confirm their relationship. Mr D and his family took the tests, at a cost of over £600.

In early summer 2014 the test results confirmed Mr D's son was his and his wife's child. A few days later, HM Passport Office issued his passport. However, because the passport had to be sent abroad securely, HM Passport Office told Mr D it would take three to four weeks to arrive.

Mr and Mrs D called HM Passport Office to find out when and where their son's passport would be sent on a number of occasions until mid-summer 2014 when he received it.

Mr D complained to HM Passport Office about the need to undertake DNA testing and asked for a refund of the fees. He also complained about the length of time taken to issue his son's passport. He said HM Passport Office's website advised the application would take four to six weeks. HM Passport Office considered the complaint, but concluded Mr D should pay for the DNA testing because it had dealt with the application properly.

What we found

We partly upheld this complaint. We found no evidence that HM Passport Office failed to deal properly with Mr D's application for his son's first passport or that the DNA tests were unnecessary in deciding his son's application. As Mr D's son was born overseas, HM Passport Office had to be satisfied that the child was his and his wife's. DNA testing was the only sure way of establishing this. Once the DNA testing had proved this, HM Passport Office issued a passport without delay. We also found no evidence that HM Passport Office failed to deal properly with his formal complaint

However, we found that HM Passport Office did not keep Mr D properly informed about the changes to the timescale for dealing with applications from abroad or how he would receive the passport once it had been sent.

Putting it right

HM Passport Office apologised to Mr D and paid him £100 for its poor communication with him and for the inconvenience and frustration he experienced as a result.

Organisation(s) we investigated

HM Passport Office

Summary 1123/December 2015

Border Force mishandled records of a passenger's arrival into the UK

Mrs L complained about how Border Force dealt with her when she arrived to stay in the UK for the birth of her baby.

What happened

Mrs L, an overseas national, arrived in the UK as a visitor, intending to give birth to her baby, which was due six weeks later. Border Force interviewed Mrs L and asked her for evidence that she had arranged private medical treatment for the birth, and that she could afford to pay for it. Mrs L had a medical insurance certificate, but it did not say what treatment she was covered for and she did not have evidence of how much the birth would cost, or proof that she could pay for the amount Border Force estimated it would cost.

After four hours Border Force refused Mrs L entry and arranged for her to leave the UK later that evening. Mrs L told Border Force that she was not well enough to make another long flight while so heavily pregnant and asked what she needed to do to satisfy it she could afford to have her baby in the UK without using the NHS. Mrs L said the first Border Force officer told her she was fine to fly and advised her to leave and return with a visa. The second officer also told her she would be fine to fly, but said that she should return with evidence that she had medical insurance to cover all of her costs.

Mrs L then contacted her insurance company to obtain the necessary proof that she was insured for the birth. Meanwhile, the second officer had told a senior Border Force officer about Mrs L feeling unwell.

The senior officer arranged for Mrs L to be allowed into the UK pending getting the proof they needed that she could pay for the birth. However, before Mrs L was told about this decision, the insurance company sent proof by fax that she was fully insured in the UK. Mrs L was allowed into the UK, but by this point she said she had been delayed by approximately seven hours.

Mrs L said she felt extremely frustrated and distressed by what had happened. She complained to Border Force but said she did not feel all her concerns had been addressed.

What we found

We partly upheld this complaint. We found that Border Force had misplaced Mrs L's records of arrival in the UK, which meant we could not do a detailed investigation into her complaint as we would normally do. However, we found Border Force's decision to refuse her entry without the evidence needed was not unreasonable. The evidence showed that Border Force dealt with Mrs L within four hours, which was not an unusually long time. The Border Force officers who dealt with Mrs L were not obliged to offer her advice about what she could do to persuade them to change the decision. But they could have better explained to her that it was the airline's decision whether or not she was fit to fly. We could not confirm whether or not the officers involved had been rude to her, because there were no impartial witnesses.

Putting it right

Border Force apologised to Mrs L for not properly retaining her records. It also took action to improve record handling.

Organisation(s) we investigated

Border Force

Summary 1124/December 2015

Ofcom apologised for not keeping a consumer informed

Mr H wanted British Telecommunications (BT) to supply him telecommunication services but it declined because it did not own the cable network. Mr H complained to the Office of Communications (Ofcom) and the Department for Culture Media and Sport (DCMS) but was unhappy with their responses.

What happened

Mr H moved into a new housing development area made up of 500 properties. The developer, when installing the telecommunications cable network, had entered into an agreement with another company (Company A), rather than BT. Access to the telecommunications network was made available through Company B (a subsidiary of Company A).

However, Mr H wanted BT to supply telecommunications services rather than Company B. BT declined Mr H's request because it had not installed the infrastructure in the development area and Company A only allowed Company B access to its network. BT had not been able to reach a commercial agreement with Company A over access to its telecommunications network.

Mr H complained to his MP about a telecommunications monopoly in his area. In early 2014 the MP wrote to the Minister responsible for implementing government policy on communications issues in the UK at DCMS about the matter.

The Minister replied saying it was not Company A restricting access to its network, but BT was unwilling to connect to Company A's infrastructure and instead wanted to install its own. The Minister suggested that Mr H should contact Ofcom if he thought BT was being unreasonable.

Mr H complained to Ofcom about BT's refusal to give him telecommunications services. He said that the regulations in place meant BT was under a statutory obligation to provide a service to him and others in the area. Ofcom considered Mr H's complaint, but in summer 2014 decided not to open an investigation into the matter. Mr H immediately complained to Ofcom again about the situation, adding that as a result he was paying more for telecommunications services and that Company A did not give access to the services available to disabled and low income consumers. Ofcom considered Mr H's fresh allegations, but in autumn 2014 it again decided not to open an investigation because Mr H had access to the public communications network at a reasonable price from Company A.

Later Mr H asked Ofcom how he could challenge that decision. His MP also wrote again to the Minister at DCMS asking how Mr H could challenge Ofcom. The Minister replied setting out Ofcom's review process. In spring 2015 Ofcom replied to Mr H about how he could challenge its decision. That same month Mr H sought a review of Ofcom's decision. Ofcom reviewed the matter and concluded it had decided his complaint appropriately, leaving Mr H without a service from BT.

Mr H complained to us that he had been denied services he had the right to as a member of the public and wanted service improvements.

What we found

We partly upheld this complaint. We found no evidence that either Ofcom or DCMS had failed to respond to Mr H's complaints that BT was breaching the telecommunications regulations. However, we found that Ofcom had failed to deal with Mr H's complaints as promptly as we would expect.

Putting it right

Ofcom apologised to Mr H for the frustration caused by its poor communication with him when dealing with his concerns.

Organisation(s) we investigated

Office of Communications (Ofcom)

Department for Culture, Media and Sport (DCMS)

Summary 1125/December 2015

Border Force acted properly when it stopped and detained a man but mishandled his subsequent complaints

Border Force's decision to stop and detain Mr S before allowing him into the UK was reasonable. However, it mishandled his complaints about its actions as it took too long to reply and also refused to tell him why he had been detained.

What happened

Mr S arrived in the UK as a visitor in summer 2014 just after 5.30pm. He said, on the landing card that he had completed, that while in the UK he was '*hoping not to kill anyone*'. The Border Force immigration officer responsible for his first examination, asked Mr S what he intended to do in the UK and he reiterated that he was hoping not to kill anyone. However, he said that he had gone on to explain that he was joking.

Border Force said the immigration officer concluded that it was appropriate for Mr S to be examined further before allowing him into the UK on the basis that he had failed to give satisfactory or reliable answers to the questions put to him on arrival. At 7.15pm another Border Force immigration officer interviewed Mr S and decided that he satisfied the requirements to be allowed into the UK, noting he had been '*very open and honest*' with his replies. At 9.40pm the immigration officer granted Mr S entry to the UK, four hours after arriving.

When Mr S returned home he complained to Border Force about the experience. He said Border Force incorrectly and unfairly detained him for seven hours at the airport.

He also complained that Border Force had not addressed and resolved the issues he had complained about. Mr S said Border Force's actions had caused him to feel annoyed and frustrated and he wanted Border Force to tell him why it had decided to detain him.

Border Force considered his complaint and said it had dealt with him appropriately and had not detained him unnecessarily. It also added that it had a policy of not telling passengers why they had been selected for further examinations.

What we found

We partly upheld this complaint. We found Border Force had detained Mr S because of the comment he had made on arrival, which meant it had to be sure he was not a risk to people in the UK. We found it acted properly at every stage of his detention and let him in for his holiday as soon as it was satisfied he was not a risk and was a genuine visitor. We also did not find Border Force had detained Mr S for an unreasonably long time. The records confirmed that he had been detained for four hours after arriving, which we considered reasonable.

However, we found Border Force did not deal with Mr S's complaint as well as it should have. It took too long to respond to his first complaint about its actions and refused to tell him why he had been detained when he asked it to in his second complaint.

Putting it right

Border Force apologised to Mr S for the poor complaint handling we identified in our investigation report and its impact on him.

Organisation(s) we investigated

Border Force

Complaints about the NHS in England

Summary 1126/October 2015

Missed opportunity to diagnose bladder cancer sooner

Mr B complained that the Trust failed to diagnose his late grandfather's bladder cancer sooner. He believed that, had his grandfather received better care, he would not have died in hospital. The Trust's poor complaint handling also added to his distress.

What happened

Mr G had a number of medical conditions. In autumn 2006 his GP referred him to a consultant urological surgeon because of increased urination and blood in his urine. Tests were carried out but most of them were normal. Mr G was discharged from the surgeon's care but an appointment was made for him to see a nurse specialist four months later, to have a repeat scan of his bladder.

Mr G's symptoms remained unchanged, and in spring 2007 he saw the same surgeon again. The surgeon decided no treatment was needed and that Mr G should see the nurse specialist in six months' time. But the nurse specialist saw Mr G over a year later in summer 2008. The nurse specialist was concerned about Mr G's symptoms and wrote to the surgeon, who subsequently changed Mr G's medication. Four months later Mr G's symptoms were not getting better and appeared worse. The nurse specialist felt Mr G was suffering from a urinary infection and so she asked his GP to prescribe him antibiotics. The nurse specialist had also sent a urine sample to be tested to '*ensure nothing else is going on*'.

The urine test results showed numerous cells that could indicate cancer and so Mr G's GP referred him for more tests. The surgeon carried out a cystoscopy (a procedure to look inside the bladder), which showed similar findings.

In early 2010 the surgeon arranged for Mr G to have a prostatectomy (operation to remove his prostate) but this was cancelled because he was due to have a heart operation and was considered high risk. But after the heart operation and discharge from cardiologist's care, Mr G had a prostatectomy towards the end of 2011. However, his urine continued to show abnormal cells and at the end of 2011 Mr G had a cystoscopy that showed a solid lesion in his bladder. This was cancer. Mr G received radiotherapy for this.

In spring 2012 Mr G went to A&E with abdominal pain, discomfort passing urine, poor appetite, nausea, lethargy and weakness. He was admitted to hospital and quickly discharged. However, he was readmitted a number of times before his final admission in mid-spring 2012. Mr G died at the beginning of summer 2012.

Mr B said that if his grandfather had received better care he would not have died. He wanted an apology, service improvements and payment.

What we found

We partly upheld this complaint. We found that Mr G's care and treatment up until and including the appointment in spring 2007, was reasonable. However, after this date abnormal test results were not always acted upon as they should have been. There should have been a greater suspicion of cancer. There was a general lack of attention to detail in 2012 when Mr G was admitted and discharged quickly a number of times. However, during his final admission the care he received was reasonable, with the exception of the care he received in relation to his pain needs.

Mr G therefore experienced symptoms for longer than necessary, and there was a missed opportunity to potentially prevent Mr G developing invasive cancer. Mr G experienced unnecessary pain because he was discharged when he should not have been, and during his final admission there was no evidence that his pain needs were met.

Putting it right

The Trust apologised to Mr B for the failings we identified, paid him £1,500 for the injustice caused by those failings, and put in place an action plan that addressed the failings.

Organisation(s) we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

East

Summary 1127/October 2015

Surgery was performed without patient's consent

Mrs E complained about the care and treatment she received for her numerous medical issues. She said the Trust did not obtain her permission before carrying out an operation on her piles. She also complained about the Trust's complaint handling.

What happened

Mrs E had various medical issues including problems with her feet, left kidney, piles, asthma, and lumps under the skin.

Mrs E complained about the treatment she received for her piles, in particular, that the growths around her anus were banded without her consent. Banding involves placing a very tight elastic band around the base of piles, to cut off their blood supply. The piles should then fall off within about a week. She said the surgeon did not tell her he had done this immediately afterwards. The surgeon said he told Mrs E that he had banded her piles and warned her that she might suffer bleeding. He also claimed to have given her pain killing medication during the procedure. But the surgeon did not make a note of this conversation, and Mrs E disputed both these points. She said she woke up from the procedure in pain.

The Trust discharged Mrs E despite the fact that she was losing a lot of blood and she had not eaten anything or gone to the toilet; and Mrs E said the Trust failed to give her any paperwork explaining what had been done or give her the four items she had been prescribed. She said this caused her and her family distress and that she was '*made to feel dirty, embarrassed and humiliated*'.

Mrs E said that staff at the Trust treated her discourteously and insensitively. She also complained about incorrect diagnoses in her clinical records and the Trust's refusal to amend them. She said she did not receive adequate care and treatment for her medical problems. Mrs E also complained about the Trust's poor complaint handling.

What we found

We partly upheld Mrs E's complaint. We found service failure in the treatment Mrs E received for her piles and this caused an injustice to her. We found the surgeon banded Mrs E's piles without her permission and he could not provide evidence that he got her consent. Mrs E said the surgeon failed to tell her that he had banded her piles immediately after the operation, which the surgeon disputed. Our clinical adviser said people often forget what they are told shortly after they wake up from an operation. Therefore, Mrs E may have forgotten being told her piles had been banded. There was no independent evidence, and nothing in the clinical records, to support one account over the other, and so we did not make a finding on this aspect of Mrs E's complaint. We did not find failings in the Trust's handling of Mrs E's complaint, and we did not find service failure in relation to any other aspect of Mrs E's complaint.

Putting it right

The Trust wrote to Mrs E and apologised for the service failure in the care it gave her and for the distress caused. The surgeon discussed what he had learned from this complaint with his responsible officer. The Trust also drew up an action plan to prevent this from happening again.

Organisation(s) we investigated

Pennine Acute Hospitals NHS Trust

Location

Greater Manchester

Region

North West

Summary 1128/October 2015

Ambulance crew missed stroke symptoms

An ambulance crew failed to properly assess a young man in his early twenties when he suffered a stroke. They also failed to take him to the right hospital that could have diagnosed and treated his rare stroke.

What happened

Mr R became suddenly ill in summer 2013. He complained of a migraine, vomited a lot and felt drowsy. He went to bed but when he woke up he couldn't use his legs and his speech had begun to slur. His family called an ambulance. Although Mr R had problems moving and speaking, the ambulance crew did not carry out a Face, Arms, Speech and Time (FAST) assessment to see whether he might be having a stroke. The ambulance crew took him to the Hospital Trust rather than the specialist stroke centre.

Mr R's sister, Ms R, said the ambulance crew transported Mr R in a sitting position in a wheelchair and this put his airway at risk as his consciousness level deteriorated. The ambulance did not put the lights and siren on, did not monitor Mr R properly during the journey to hospital and key information about his symptoms was not passed on in the handover at A&E. Mr R had a greatly reduced level of consciousness and he was struggling to breathe on arrival at A&E.

Mr R had various investigations in hospital. However, his stroke was not diagnosed until the fifth day of his stay in hospital. It was too late for any treatment that might have reduced his level of disability.

The stroke left Mr R with 'locked-in syndrome' (where someone is unable to move or speak but has full cognitive abilities). He is able to blink and move his eyes but has no other control over his body.

Mr R's sister, Ms R, complained about the care and treatment the ambulance crew and the Trust gave him. She believed that if her brother had been assessed properly, he would have been taken to the specialist stroke centre, where he would have had specialist care and a better outcome. Although the Ambulance Trust acknowledged some failings and took action in relation to the ambulance crew, Ms R remained unhappy with its response regarding the FAST assessment and choice of hospital. Ms R wanted a payment to help with the cost of meeting her brother's needs.

What we found

We partly upheld this complaint. We found that the ambulance crew failed to carry out a FAST assessment and failed to note that Mr R was FAST positive. They also failed to record key information about his history and symptoms and communicate these to hospital staff. They should have taken Mr R to a specialist stroke centre and alerted it that they were on their way. They should also have monitored and reported his deteriorating condition on the way, and transport to hospital should have been under emergency conditions (lights and siren).

These failings made it much more difficult for doctors to make an accurate diagnosis quickly. The failure to alert the emergency department meant it had no chance to prepare to meet Mr R's immediate needs.

If Mr R had been taken to the stroke centre as a FAST positive patient with a pre-alert to the stroke team, it was likely that the stroke would have been diagnosed much sooner than it was. The failings meant that Mr R did not get the care he should have had and the chance (however small) of a better outcome.

Failings at the hospital also led to avoidable delay in diagnosis. There was inadequate history taking from family members, which meant key information pointing to the stroke was not captured. The reason for the rapid drop in consciousness level was not adequately considered and intensive care unit doctors did not document robust neurological assessments, so opportunities to make an earlier diagnosis were missed. But this delay did not affect the level of disability Mr R ended up with. The appropriate treatment was not available at the hospital and Mr R could not be transferred due to the seriousness of his condition.

The failings left Mr R and his family with some uncertainty about his abilities and neurological state at different times during the first five days.

Putting it right

The Ambulance Trust had not fully acknowledged all failings before the complaint came to us. It had acknowledged failings in the conduct of both members of the ambulance crew. It identified that one of the paramedics had not acted in line with the relevant standards of performance, conduct and ethics because he failed to act in the best interest of Mr R. The Ambulance Trust took disciplinary action against him. However, it had not acknowledged failings in relation to the FAST assessment and transportation to the Hospital Trust.

The Ambulance Trust accepted our recommendations and wrote to Mr R acknowledging all failings and apologised for the impact these had had on him and his family. It also paid him £2,000 in recognition of the loss of opportunity he experienced, and the uncertainty he and his family have to live with.

The Hospital Trust had acknowledged some issues with communication and neurological assessment before the complaint came to us. However, it said the overall care and treatment was appropriate. Following our investigation, it accepted our recommendations and wrote to Mr R acknowledging the failings we identified, and apologised for the impact on him. It also paid Mr R £250 in recognition of the impact of its failings on him.

Organisation(s) we investigated

Central Manchester University Hospitals NHS Foundation Trust

North West Ambulance Service NHS Trust

Location

Greater Manchester

Region

North West

Summary 1129/October 2015

Trust failed to carry out appropriate assessments before discharging patient

Mrs T said the Trust did not give her appropriate care and treatment during the birth of her daughter. She said midwives did not listen to her birth preferences and doctors discharged her too quickly following the birth. She also complained about the care and treatment given to her daughter.

What happened

Mrs T was admitted to the Trust in late 2012 for her labour to be induced. Her daughter was born three days later. Mrs T suffered a bleed immediately after her daughter's birth and needed a blood transfusion. Following her discharge, Mrs T was readmitted to the hospital because she was in heart failure (a condition caused by the heart failing to pump enough blood around the body at the right pressure), had breathing difficulties and swollen legs. Her daughter was also admitted with breathing and feeding difficulties but doctors found her to be healthy.

Mrs T's daughter was later readmitted to the Trust because Mr and Mrs T were still concerned about her breathing. Doctors diagnosed Mrs T's daughter with early bronchiolitis (a common illness that affects the airways) and discharged her. Mrs T returned to the Trust again in early 2013 because she was still concerned about her daughter's wellbeing. Her daughter had signs of severe breathing difficulties and doctors transferred her to a specialist children's hospital. Doctors there diagnosed her with laryngomalacia (noisy breathing in infants and children).

Mrs T said the Trust's failings led to her experiencing unnecessary distress during labour. She said she was readmitted to hospital for blood transfusions and nursing care, which could have been avoided if the Trust had not sent her home when she was unwell. She believed the Trust's failings had also led to her suffering long-standing chest problems, her daughter's delayed diagnosis led to her (Mrs T) experiencing extreme distress and her daughter suffered unnecessarily. She wanted service improvements at the Trust and a payment for the distress she experienced.

What we found

We partly upheld this complaint. We found that the Trust did not establish whether Mrs T was medically stable or fit for discharge. It had not checked that all tests and investigations were within the normal range and had not carried out an appropriate assessment of Mrs T's physiological, social, functional and psychological factors.

However, we found that Mrs T's labour and delivery, and the care that midwives gave, was appropriate. We also found the Trust adequately investigated her daughter's breathing difficulties and the care given was in line with established good practice and national guidance.

Putting it right

The Trust acknowledged the service failure we identified and apologised to Mrs T. It paid her £350 in recognition of the distress caused. The Trust also produced an action plan, which described how it would prevent the same issues happening again.

Organisation(s) we investigated

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Location

South Yorkshire

Region

Yorkshire and the Humber

Summary 1130/October 2015

Missed opportunity to involve family in safeguarding concerns

Mrs Q complained about the care and treatment her son, baby V, received from four trusts. She said a scan did not identify anomalies in her son's growth, and that childcare and safeguarding concerns had been inappropriately raised about his family.

What happened

Baby V was born with severe genetic defects. During his 17-week life, baby V was taken by his family to three different trusts and was cared for in the community by a fourth. Baby V died under the care of a fifth trust during surgery.

Mrs Q said that the first Trust failed to identify any anomalies in the growth of her son at her 20-week scan appointment. When baby V was born, the first Trust did not tell Mrs Q about baby V's genetic defects and did not carry out all the necessary investigations, so some of his conditions went undiagnosed. The first Trust also failed to refer baby V to the fifth hospital (which was not part of our investigation). Mrs Q believed that if baby V's conditions had been identified at her twenty-week scan, she, her family and the first Trust's staff would have been better prepared for baby V's care once he was born.

Mrs Q's complaint about the second Trust was similar to the first Trust. She said the second Trust did not highlight a missing organ on baby V's discharge summary, some conditions went undiagnosed and the second Trust did not carry out all necessary investigations. Mrs Q also said baby V's family was misrepresented in his medical records to show them in a bad light.

Mrs Q said the third Trust inappropriately raised safeguarding and child protection concerns and made false allegations about baby V's family.

Mrs Q also complained that the fourth Trust's report regarding safeguarding concerns that a children's community nurse had written, was inaccurate, untrue and portrayed baby V's family in a bad light.

Mrs Q said the actions of all these trusts had caused her and her family anxiety and distress for which they wanted an apology.

What we found

We partly upheld Mrs Q's complaint. We did not uphold her complaints about the first and third Trusts. We found that none of the conditions baby V was born with would have been identified on the 20-week scan. Therefore, there were no failings in the conclusions reached by the first Trust from the images shown by baby V's 20-week scan. We did not find failings in the first Trust's failure to refer baby V to the fifth Trust because there was no reason to. Baby V was being diagnosed step by step, and had he stayed at the first Trust longer than he did, some of his conditions would eventually have been picked up. This would also have included confirming the absence of a certain organ. We did not identify any other diagnoses or investigations that the first Trust should have made or done. Although there were shortcomings in the care baby V received from the first and third Trusts, we did not find these had caused an injustice.

The second Trust was aware of baby V's missing organ because it was stated on the discharge summary sent to it by the first Trust. However, given that the second Trust planned to test baby V's immune system as an outpatient on discharge, we did not identify injustice as a result of this failing. Overall the second Trust gave baby V good care and treatment.

With regard to baby V's family being misrepresented in a bad light and the concerns relating to safeguarding, we were satisfied that the type of entries made in his medical records were in the spirit of the relevant guidance and relevant to the situation. The second, third and fourth Trusts were right to have safeguarding concerns and shared information about their concerns appropriately. However, we identified that it was a serious matter to make a safeguarding referral. As such, the second and fourth Trusts should have had conversations with baby V's family about safeguarding concerns. Not doing so meant the family were denied the opportunity to explain the reasons for their actions. This was an injustice to the family. We acknowledged that baby V's family had his best interests at heart.

Overall, the Trusts said that they found baby V's family difficult to develop a relationship with and there were a number of times when his family removed him from hospital against medical advice.

Putting it right

The second and fourth Trusts apologised to Mrs Q and produced action plans to prevent similar failings in the future.

Organisation(s) we investigated

North Middlesex University Hospital NHS Trust (first Trust)

Barts Health NHS Trust (second Trust)

Imperial College Healthcare NHS Trust (third Trust)

North East London NHS Foundation Trust (fourth Trust)

Location

Greater London

Region

London

Summary 1131/October 2015

Mistakes by NHS bursary scheme caused overpayment

The NHS Business Services Authority (NHS BSA) failed to process Mrs S's change of circumstances application properly, resulting in an over-payment of almost £4,000 for her NHS bursary. It asked her to repay it. Mrs S was not happy with NHS BSA's decision and subsequently complained to the Department of Health about the NHS BSA but was dissatisfied with its complaint handling.

What happened

Mrs S applied for an NHS bursary for the academic year 2013-2014 to undertake a midwifery training course. She received an award notice (letter granting payment) but four days later called NHS BSA and said she had omitted to include all her income on the application form; she had not included a bonus received at the end of the financial year in 2012.

The NHS BSA told Mrs S the bonus would not affect her award but she should fill in a change of circumstances form so that the bonus could be added to her income for the relevant period. Mrs S sent the form with a covering letter on the same day. She tracked progress of the form on her NHS BSA online account. The online account showed the form had been received and then processed, and there was no change to the award.

However, when Mrs S applied for an NHS bursary for the second year of the course, she received a smaller bursary. She called NHS BSA to query the amount and she was told it was because her husband's income had increased during the relevant period, so she was no longer entitled to Dependants' Allowance.

The next day the NHS BSA called Mrs S to tell her a compliance check of the previous year's bursary found that the change of circumstances form had not been processed correctly and the 2012 bonus had not been included in the award calculation. The NHS BSA said that Mrs S had been overpaid by nearly £4,000 the previous year.

The NHS BSA admitted the overpayment was due to its mistakes but it refused to cancel the debt because Mrs S had agreed to repay any overpayment when she accepted the conditions for getting the bursary. This included agreeing to repay any amount paid in excess of entitlement (including in the case of administrative error). Mrs S was offered the option of deferring re-payment until the end of her course.

Mrs S said she was unable to repay or defer repayment and this had affected her financially and emotionally. She decided she could no longer afford to continue with her training and gave up her place before the course ended. This resulted in a further overpayment but she repaid it as soon as she received the invoice from NHS BSA.

Mrs S complained to the Department of Health about NHS BSA. The Department of Health responded saying it was a condition of applying and accepting NHS bursary support that students agree to repay bursary money they receive to which they are not entitled, however this occurred.

Mrs S was unhappy about the Department of Health's complaint handling and complained to us. She wanted the debt to be written off and for NHS BSA to make service improvements.

What we found

We partly upheld Mrs S's complaint about NHS BSA. We found NHS BSA got it wrong twice: first, when it said the 2012 bonus would not affect the amount of the bursary already awarded to Mrs S, and secondly, when it failed to process the change of circumstances form properly. If the first error had not occurred and Mrs S had been correctly told that she would not be entitled to Dependants' Allowance when the bonus was included in her income, she may well have contacted the NHS BSA when her online account showed no change to the award. As it was, what happened was what the call centre operator told Mrs S would happen so it was reasonable for her to assume this was correct. The NHS BSA could not explain why the change of circumstances form was rejected without the bonus being processed.

The NHS BSA expects students to repay overpayments. It should therefore take care to get the awards right and take appropriate steps to minimise the risks of mistakes occurring. It seemed to us it was an unlikely coincidence that the NHS BSA happened to do a quality assurance check 11 months after the first year award, the day after Mrs S queried the second year award. The NHS BSA failed to do a timely quality assurance check to identify and correct the error in the first year award.

The NHS BSA's mistakes caused Mrs S to be overpaid by nearly £4,000 even though she acted in good faith and in time to correct her error.

We did not uphold Mrs S' complaint about the Department of Health's poor complaint handling because we did not identify any serious administrative errors in its actions.

Putting it right

NHS BSA accepted our recommendations to put things right for Mrs S. It apologised and cancelled the overpayment. NHS BSA also agreed to review the circumstances leading to Mrs S' complaint and identify the actions it needs to take to reduce the risk of overpayments arising from administrative errors in future.

Organisation(s) we investigated

NHS Business Services Authority (NHS BSA)

Department of Health

Location

UK

Region

UK

Summary 1132/October 2015

Poor care and treatment of patient at the end of her life

A patient was inappropriately taken off her breathing machine and her daughter's advice was disregarded, causing fear and distress at the end of the patient's life.

What happened

Mrs M suffered from several long-term medical problems. She was admitted to hospital with worsening respiratory problems. She used a BiPAP (respiratory) machine on the ward. Mrs M was nearing the end of her life and a junior doctor took her off her BiPAP machine in the belief that she needed oxygen via a face mask. Mrs M's daughter, Mrs O, a nurse with experience of her mother's condition, was unhappy with this and discussed it with staff, and begged the ward nursing staff to keep her mother on the BiPAP as well as receiving oxygen. Eventually Mrs M was put back on the machine but this took some time. Unfortunately Mrs M's condition deteriorated and she died.

Mrs O said the junior doctor had not properly assessed Mrs M or consulted with a senior doctor before taking her off the BiPAP machine. When she asked staff to put Mrs M back on the machine it took some time and the intensive care registrar was not called to be involved until Mrs O became upset.

Mrs O complained about the actions and attitudes of the junior doctor, as well as the nurse that was involved. She said as a result of these issues her mother suffered unnecessary pain, fear, and distress in her final hours.

Mrs O herself was very distressed by witnessing her mother's suffering. She also complained about the Trust's complaint handling, and wanted an apology, service improvements and payment for the distress caused.

What we found

We upheld this complaint. We found that Mrs M could have been kept on her BiPAP machine and been given oxygen at the same time. We found there was no special need to involve the intensive care registrar at any stage. However, it was appropriate for his assistance to be requested by the ward doctors when they ran into difficulties with Mrs M's BiPAP machine.

We saw evidence to support Mrs O's assertion that Mrs M suffered because of the junior doctor's uncertainty and lack of confidence in managing her. This had an adverse impact on Mrs M and her daughter.

We also found that the complaint handling was prolonged and unsatisfactory, causing additional distress to Mrs O.

Putting it right

The Trust acknowledged and apologised for the impact of the failings and poor complaint handling we identified. It paid Mrs O £750 in recognition of the impact these failings had on her. The Trust also shared an action plan with Mrs O showing its improvements to complaint handling.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 1133/October 2015

Trust failed to make referral to the Court of Protection which caused unnecessary distress

Mr L and Ms K complained about the care and treatment given to their father, Mr R, between autumn 2013 and early 2015. Mr L and Ms K believed that hospital staff acted against their father's end of life care wishes. This caused the family continued distress and anxiety and prevented them spending quality time with their father in the year before his death.

What happened

Mr R had a history of diabetes, heart attack, angina attacks and high blood pressure. In autumn 2013 he had a stroke and was admitted to hospital with a two-day history of worsening mobility, slurred speech and right arm weakness. The Trust made a decision to feed Mr R using a nasogastric (NG) feeding tube. Between spring 2014 and early 2015, Mr R was readmitted to hospital a number of times because he kept removing the tube resulting in episodes of hypoglycaemia (low blood sugar levels). On one occasion a bridle (supporting Mr R's feeding tube) and mitts were fitted to reduce the chance of him pulling out the NG tube.

The Trust considered fitting a percutaneous endoscopic gastrostomy (PEG) feeding tube (a tube is passed through the abdominal wall to provide a means of feeding) and discussed this with Mr R's family. However, following the PEG assessment, the Trust concluded that Mr R was not a suitable candidate for PEG placement because it was felt his survival was only likely to be six to 12 months.

The family confirmed they did not want a PEG to be fitted and said Mr R had previously indicated that he did not want this type of intervention. Speech and language therapists advised the continued use of NG feeding.

The Trust at some point stopped the NG tubes. It discussed PEG placement again with the family but the family reiterated that they did not consider a PEG placement to be appropriate. The Trust restarted the NG feeding but advised Mr R's family that long-term NG feeding was no longer an appropriate option.

In summer 2014 the Trust made a Deprivation of Liberty (DoL) application to the local authority (DoL aims to make sure that any care that restricts a person's liberty is both appropriate and in their best interests). The local authority authorised Mr R's DoL but subject to the Trust making an urgent application to the Court of Protection (CoP) in relation to the parental feeding methods proposed, which the family were objecting to. It was also in relation to Article 8 of the European Convention of Human Rights (ECHR), that is, the right to respect for private and family life, his home and his correspondence. The CoP makes decisions on financial or welfare matters for people who cannot make decisions at the time they need to be made because they 'lack mental capacity'.

However, the local authority later became aware that Ms K had a Lasting Power of Attorney (LPA) over Mr R's health and welfare. It cancelled the DoL order and confirmed its reasons with the Trust. It added that it would be unlawful for the Trust to continue Mr R's care under the DoL scheme. The Trust did not make an application to the CoP.

During early 2015 the Trust made a decision that no further NG tubes would be replaced. It also commissioned an independent clinician to examine Mr R and help mediate between the Trust and the family.

Following a meeting between the Trust and Mr R's family, together with the legal representatives of both groups, it was agreed that Mr R should be discharged home with palliative care. However, Mr R was readmitted two days later at the request of his family. He died shortly afterwards in early 2015.

Mr L and Ms K complained about the care and treatment given to their father; that the Trust incorrectly informed them in spring 2014 that their father was dying; that on one occasion the bridle supporting their father's feeding tube was fitted too tightly, which cut his nose; that they had an ongoing dispute regarding their father's nasogastric feeding tube, which at times delayed discharges from hospital; and that the Trust tried to force the use of a PEG against Mr R's and the family's wishes.

What we found

We partly upheld this complaint. We found some aspects of care were appropriately given and did not lead to any significant problems. The information the Trust gave to the family in spring 2014 about the possibility of Mr R dying was also appropriately provided. The NG bridle was fitted too tightly initially but this was corrected soon afterwards and Mr R did not come to any longer-term harm.

However, when the Trust failed to make a referral to the CoP, this caused Mr R's family unnecessary distress and anxiety because a decision was made to eventually stop NG feeding and start palliative care.

Putting it right

The Trust wrote to Ms K and Mr L acknowledging the failings we identified and apologised for the impact they had had on Mr R and his family. It paid Ms K and Mr L £500 in recognition of the injustice we found.

In addition, the Trust produced an action plan to address the faults identified in our report.

Organisation(s) investigated

Lancashire Teaching Hospitals NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 1134/October 2015

Failings in care for a man at risk of suicide

Two trusts failed in their care of a man at risk of suicide, but it was unlikely they could have prevented his suicide.

What happened

Mr N called a housing support group for people with mental health issues. He left a voicemail message saying he was going to kill himself. He left the same message again later. A staff member and a social worker went to Mr N's house but he refused to open the door or answer further phone calls. The police later arrested Mr N and detained him under section 136 of the *Mental Health Act 1983*. The police then took Mr N to hospital (part of the mental health Trust) for a *Mental Health Act* assessment.

At the mental health Trust Mr N appeared drowsy and confused and so the assessment was stopped. Mr N confirmed he had taken an overdose of prescription medicines. Staff did not consider him to be fit for an assessment until the effects of his overdose had been treated. They called an ambulance and Mr N went to A&E at the acute Trust.

When Mr N arrived at A&E, staff assessed his suicide risk and concluded that he had a higher risk of suicide. A doctor from the mental health Trust noted that Mr N was drowsy and that he said he wanted to die. However, Mr N said he was happy to stay in hospital. The doctor also noted that Mr N would be at a high risk if he was sent home. He said a doctor would need to carry out a further mental health assessment when Mr N was physically fit and less drowsy.

Two days later Mr N left the acute Trust, and took his own life.

Mr N's friend complained about the poor communication between the two organisations, the inadequate monitoring that staff offered to Mr N when he was in hospital and why he was allowed to leave the hospital so freely given his risk of self-harm. She wanted service improvements, particularly in communication and consistency of care.

What we found

We partly upheld this complaint. We found that nurses should have observed Mr N more frequently. The doctor who attended from the mental health Trust should have made it clear what the level of observation should have been and staff at the acute Trust should have recognised the need for more frequent observations. However, we did not conclude that increased observations would have led to a different outcome. It is likely the frequency of observations would have reduced by the time Mr N left hospital, even if they had been implemented. In any case Mr N would still have been able to leave the hospital if he wanted to. We also found that nurses at the acute Trust should have been more alert to Mr N's prolonged absence from the ward. But even if they had taken action it is unlikely that this would have led to a different outcome. While we found there were significant failings by both Trusts, we did not find that they contributed to Mr N's death.

Putting it right

Both Trusts prepared action plans to show what they had learned from the complaint.

Organisation(s) we investigated

Tees, Esk and Wear Valleys NHS Foundation Trust (mental health Trust)

South Tees Hospitals NHS Foundation Trust (acute Trust)

Location

Middlesbrough

Region

North East

Summary 1135/October 2015

Missed opportunity to diagnose and treat patient's severe headache sooner

Mrs F complained that the care and treatment she received while she was a patient at the Trust was inadequate. She said that as a result she had been left in pain and lost hearing in her left ear. Mrs F also complained about the way her complaint was handled.

What happened

Mrs F gave birth to her son in spring 2014 and was given an epidural to help with the pain.

It took four attempts to place the epidural into position and on one occasion Mrs F suffered '*electric-shock-like pain*' down her left leg. During the night and the following morning Mrs F started to suffer with a headache and felt dizzy. She also complained that her hearing was reduced in her left ear. She was diagnosed with a postdural puncture headache (a dura is one of the membranes that surrounds the brain and spinal cord) and was given a blood patch (an injection of the patient's blood into the epidural space) the next day. Mrs F's headache improved and she was discharged home.

Mrs F returned to the Trust a few days later and was diagnosed with a urinary tract infection and muscular pain. She was prescribed antibiotics and pain relief before being discharged home. Mrs F continued to feel unwell for the following few weeks and saw her GP a number of times during this period.

She eventually returned to A&E because she was suffering with a headache and ringing in her ear. She was diagnosed with vertigo and prescribed two types of painkillers.

Mrs F continued to feel unwell and, following a number of appointments with her GP, an anaesthetist and neurologists, she was diagnosed as still having a dural puncture and was given a repeat blood patch in summer 2014. Mrs F continued to suffer from headaches, pain in her back and neck and was diagnosed with tinnitus (ringing) in her left ear.

Mrs F said her experience had been very distressing and she was unable to enjoy the first few months with her baby son because of problems with her health. She wanted an apology for any failings in her care and a consolatory payment, and for the doctor who saw her in A&E in spring 2014 to be identified. In its response to the complaint the Trust said that it could not identify who the doctor was that saw her in spring 2014.

What we found

We partly upheld this complaint. We found that there was a missed opportunity for the Trust to diagnose and treat Mrs F's dural puncture sooner, which may have led to a better outcome for her in relation to the ongoing symptoms she suffers with. She should have been referred to a specialist to review her condition in spring 2014 but this did not happen.

We also found that the Trust failed to give Mrs F a fully accurate and evidence-based response to her complaint, which caused her frustration. The doctor who saw her could be identified from the Trust's A&E records but the relevant records had been filed separately to Mrs F's main hospital notes.

We did not find failings with regard to Mrs F's other concerns about her care.

Putting it right

The Trust acknowledged the failings we identified and apologised to Mrs F for the impact they had had on her. It paid her £500 in recognition of the distress and frustration that she suffered.

The Trust also prepared an action plan to show that appropriate steps had been taken to prevent the failings we identified.

Organisation(s) we investigated

The Princess Alexandra Hospital NHS Trust

Location

Essex

Region

East

Summary 1136/October 2016

Poor hospital discharge of older patient resulted in family paying for extra care

Mrs P complained about the circumstances surrounding her father's fall and subsequent discharge from the Trust. She said the failings resulted in her paying £4,000 to hire an extra carer to look after her father following his discharge back to his residential home.

What happened

Mr B was in his late eighties and suffered from dementia. He was living at a residential home. In summer 2013 he was admitted to hospital with a urine infection. Two days later Mr B had a fall at the hospital. His daughter, Mrs P, said the Trust told her the fall had happened while her father was being accompanied to the toilet by two student nurses. Mr B had an X-ray but this did not identify any fracture. He was given painkillers.

After a few days Mr B was discharged from the hospital by private ambulance back to the residential home. His mobility was now limited following his fall and the residential home said it could not care for residents who were not mobile. It suggested to Mrs P that she could pay for an extra carer to help with her father's needs. Mrs P decided to employ a carer for four weeks at a cost of £1,000 per week.

Mrs P complained to the Trust about her father's fall and discharge from the hospital. She said the failure by the student nurses to properly supervise her father in hospital meant that the family had to pay for a private carer to look after him when he returned to the residential home.

She also complained about the unsuitable type of ambulance that was arranged to transport her father and that the Trust failed to provide any type of ongoing support following her father's discharge.

The Trust said Mr B had been assessed as being at low risk of falling and that he was mobile with a zimmer frame. The Trust confirmed that there were no student nurses on duty on the day of Mr B's fall and could not identify the nurse who had phoned his family. It apologised that it could not give exact details of the fall as no incident form had been completed. It said Mr B was reviewed by a doctor after his fall and no injuries or pain were noted. The Trust said when Mr B was discharged from hospital all his observations were within normal limits. It said he was independently mobile with a zimmer frame and therefore a seated (rather than a stretcher) ambulance was appropriate.

The Trust also said it did not have any responsibility for funding additional care to support residential homes that are unable to meet a patient's needs.

What we found

We upheld this complaint. We found failings in how the Trust assessed Mr B's risk of falling. It failed to take note of the dementia form completed by his family; the falls assessment was not robust; it failed to put in place an adequate care plan to help prevent such a fall and the provision of a zimmer frame was inappropriate. We found that the care Mr B received fell below the standards expected as set out in the National Patient Safety Agency's guidance. We found that Mr B's chances of falling in hospital were greatly increased because of these failings.

We also found that Mr B's discharge was poorly planned and rushed. Staff failed to determine his level of mobility before the discharge and failed to co-ordinate with other relevant parties such as the residential home.

This went against Department of Health's discharge guidance and the Trust's discharge policy. We found this resulted in the residential home not being able to meet Mr B's needs and extra care had to be funded by his family. This created unnecessary distress, inconvenience and financial worries for Mrs P.

Putting it right

The Trust acknowledged the failings we found and apologised to Mrs P for the impact these failings had on her. It paid her £2,000 in recognition of the additional distress and inconvenience she suffered. The Trust also produced an action plan to show how these failings would be prevented in future and shared it with Mrs P.

Organisation(s) we investigated

Calderdale and Huddersfield NHS Foundation Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 1137/October 2015

Failings in care of older patient caused family distress

Mrs T said the care and treatment given to her husband from late 2013 until he passed away in early 2014 was inadequate. She believed this lack of care led to his death.

What happened

Mr T was in his eighties and had a clinical history of chronic kidney disease, as well as bipolar disorder and depression, for which he had taken medication for some years.

Mr T was admitted to hospital in late 2013 with a high temperature and other signs that could indicate sepsis, including a high pulse rate and low blood pressure. A doctor saw him and gave him intravenous antibiotics. The doctors also carried out observations and gave Mr T medication for his raised temperature. They continued to monitor him but Mr T's kidney function continued to deteriorate over the next few days and the doctors and nurses noted that he was '*not eating well*'. He had lost roughly two and half stone in nine days. Doctors referred him to the hospital's dietician team and speech and language therapy team. Also in early 2014 Mr T's medical records showed that the physiotherapists tried to engage him in rehabilitation but he would not participate because he felt too tired. He was warned of the serious risks to his health of not moving around.

Unfortunately Mr T's condition continued to deteriorate, with a sudden decline in his lung function over the next few days, and he died in early 2014.

Mrs T complained to the Trust about the care and treatment given to her husband. She raised particular concerns about her husband's weight, stating that she believed he had '*starved to death*', possibly because of a blockage in his throat. She was also concerned about blood loss her husband experienced through having too many blood tests performed on him, at a time when his body would not have been able to replenish the supplies because of his frail condition. Mrs T also raised concerns about the prescription of a type of medication for her husband, despite her advice to the clinicians that this should not be given because it caused him confusion.

The Trust explained that it had referred Mr T appropriately to its dietician team and speech and language therapy team, and that no problems were identified with his throat. It also found no evidence of significant blood loss. Finally, it acknowledged prescribing medication for Mr T but pointed out that he had a prescription for this from his GP on admission.

What we found

We partly upheld Mrs T's complaint. We found no evidence to support Mrs T's complaints that her husband was '*starved to death*' in hospital. His dietary provision was appropriate and although he lost a significant amount of weight, this was due to fluid loss caused by his clinical condition. There was also no evidence to suggest that Mr T had been unable to eat because of a blockage in his throat that had prevented him from swallowing. We found no evidence to support Mrs T's concern that her husband '*bled to death*' or required blood transfusions that were not given. We also found that the prescription medication for Mr T was reasonable in the circumstances, even though this was contrary to Mrs T's wishes.

However, Mr T's antibiotic treatment regime was not timely, was inappropriate for his condition and was not modified to take account of his poor kidney function. We also noted that the fluid balance charts that were so important for managing his condition correctly were often poorly completed and inaccurate. This would have made it far more difficult for the doctors to recognise and treat his decline. Finally, we noted that there was no continuity in his medical care, which undoubtedly added to the difficulties experienced by the doctors in treating his condition.

We found that these issues amounted to service failures and that Mr T was denied the opportunity of a potentially better outcome from his treatment, although we were unable to say with certainty whether better care would have changed the course of his deterioration. We found an injustice to Mrs T in that she was left with uncertainty about whether things could have been different for her husband, and this would likely have caused her distress.

Putting it right

The Trust accepted our recommendations and reflected on the areas of concern identified through our investigation and gave us and Mrs T information on the actions it had taken to address these. It also apologised to Mrs T for the uncertainty and likely distress she had been left with as a result of the service failures.

Organisation(s) we investigated

Royal Devon and Exeter NHS Foundation Trust

Location

Devon

Region

South West

Summary 1138/October 2015

Trust failed to confirm how it had improved its service following complaint

The Trust acknowledged that a cancer patient unfortunately experienced instances of disjointed, unprofessional and uncompassionate communication from clinicians while in hospital. But its failure to show how it had made improvements made the patient's sister feel her complaint had not been taken seriously.

What happened

Mrs L was diagnosed with lung cancer in summer 2013. She had a number of separate inpatient admissions to the Trust during the course of her treatment from autumn until her death in late 2013.

Mrs L's sister, Mrs A, complained about the care given to her sister. She had specific concerns about some aspects of her sister's care during her admissions ans also about the Trust's responses to her complaints. First, when Mrs L became unwell at home, her Macmillan nurse had got in touch with the Trust to get her admitted to hospital promptly because of the severity of her symptoms. The Macmillan nurse had told the hospital ward of Mrs L's arrival and had arranged for a bed to be ready for her. Despite this, when Mrs L arrived, a nurse on the ward refused to admit her directly and told her instead to report to A&E and await admission from there. Luckily, a nurse who knew about Mrs L's arrival and bed overheard the conversation and prevented the potentially difficult, lengthy and stressful wait in A&E.

During the same admission a doctor had advised Mrs L that a recent CT scan of her brain had been clear. But later another doctor told her that in fact the CT scan had shown that the cancer had spread to her brain. Mrs A felt strongly that her sister had been caused unnecessary stress as a result of this situation.

On another admission, Mrs L was due to be discharged home but the Trust had arranged an outpatient appointment for the following day. And when Mrs A asked if Mrs L could be seen in hospital instead, to save the journey back and forth, the Trust refused. It was only the intervention of the Macmillan nurse that ensured the appointment took place that same day, while Mrs L was still an inpatient.

Mrs A's complaint related mostly to poor communication from the clinicians, particularly a lack of compassion in breaking bad news and delays over discharge arrangements. During its own investigation the Trust fully acknowledged that Mrs L's care had been unacceptable and it apologised for this. The Trust told Mrs A that it had made a number of changes to procedures and policies to help prevent the same failings arising again in the future. It told her that it would send her evidence of these changes to reassure her that improvements had been made, but she did not hear from the Trust again. Mrs A's aim in complaining to us was to seek assurances that the relevant procedures had changed and had led to improvements in communication.

What we found

We upheld Mrs A's complaint. We saw evidence of service failure in the Trust's handling of Mrs A's complaint, which led to injustice to her. Although the Trust acknowledged that there had been service failures in Mrs L's care and undertook to make appropriate changes to practices and procedures, we found that it failed to confirm to Mrs A that it had implemented these, despite agreeing to do so.

This meant that Mrs A felt her complaint had not been taken seriously and she had to pursue it through us to get the assurances she had been seeking.

Putting things right

Through our investigation, we were able to determine that the changes set out by the Trust were indeed put in place and had led to improvements. We concluded, therefore, that a suitable and sufficient response had already been given on these points and that no further action from us was required. However, in line with our recommendation, the Trust's chief executive wrote to Mrs A to apologise for the Trust's failure to conclude her complaint adequately when she first raised it.

Organisation(s) we investigated

Imperial College Healthcare NHS Trust

Location

Greater London

Region

London

Summary 1139/October 2015

Reasonable psychiatric care for suicidal man, but insufficient information about further help

Mrs W complained about the psychiatric care given to her husband, Mr W, following his attempted suicide. She said the Trust did not give her enough information on how to access further help from the various mental health agencies, which contributed to her anxiety that there might have been missed opportunities to prevent Mr W from taking his own life.

What happened

Mr W was admitted to the Trust following an attempted suicide. He saw a Senior Specialist Nurse from the liaison psychiatry team (LPT) and was discharged two days later, with planned follow up and information about the out-of-hours' support available.

Mr W went to his follow-up appointment with the LPT a few days later where he was reported to show no signs of mental disorder or feeling suicidal. He was to see his GP the following day and had an appointment with a psychological therapies service scheduled for the following week. Mr W agreed to be discharged from the LPT service.

A few days later Mrs W phoned the crisis resolution and home treatment team (CRHT) to say Mr W had '*active suicidal ideation*' (that is, he had an existing wish to die and a plan to carry out the death). The CRHT agreed to do a home visit to assess him but when it arrived at the agreed time, Mr W had gone missing and then been found hanging. He was taken to hospital but died a few days later without regaining consciousness.

The inquest recorded a narrative verdict that Mr A '*died due to his own actions whilst suffering low mood and prescribed antidepressant medication*'.

Mrs W complained that there was a missed opportunity to prevent Mr W committing suicide. This had caused emotional, physical, psychological and financial distress to her and her family. She also said the Trust did not respond adequately to her complaint.

What we found

We partly upheld Mrs W's complaint. We found that there was a lack of information given to Mrs W about the roles of the various mental health agencies, which contributed to her anxiety that there might have been missed opportunities to prevent Mr W from taking his own life.

However, we found the care given to Mr W was in line with recognised quality standards and established good practice and that the failings we identified did not lead to a missed opportunity to prevent Mr W's sad suicide.

Putting it right

The Trust apologised to Mrs W for the impact the failings had on her. It also wrote to her to show that it had carried out the actions identified in the resolution summary of the complaint.

Organisation(s) we investigated

Northumberland, Tyne and Wear NHS Foundation Trust

Location

Northumberland

Region

North East

Summary 1140/October 2015

Surgeon did not follow original dental plan and instead extracted teeth without patient's consent

Mr C said that he did not give the surgeon consent for three of his teeth to be removed. He said that he had been distressed by this and it delayed the start of medication for another medical condition he had.

What happened

Mr C was suffering from rheumatoid arthritis and was due to start taking medication to treat it. However, he had a number of decayed teeth that required extraction before he could start the medication. Mr C said that his treatment plan involved leaving in place three teeth on the lower left side and he had dentures already made to fit around these teeth and so he would not and did not consent to their extraction.

According to the Trust Mr C attended a consultation and agreed total dental clearance. The extractions took place on three occasions in early and spring 2013. There was a further appointment arranged for the final set of extractions. However, Mr C had this done at two other hospitals in different cities.

Mr C complained to the Trust. It responded saying that the teeth it had agreed to leave in were upper right 1 (UR1), lower left 1 and 2 (LL1, LL2) and lower right 1 (LR1). It was later decided to remove UR1 and in early spring 2013, Mr C consented to the dental clearance of the lower left side of his mouth. The surgeon said that this was recorded in the dental plan.

Mr C remained dissatisfied and complained to us. He said he had been severely depressed since this happened, it had affected his speech and his self-esteem. He also said it delayed the start of medication for another medical condition he had. To resolve his complaint Mr C wanted the Trust to acknowledge its failings, apologise for them and provide a consolatory payment.

What we found

We upheld this complaint. We found that in late 2012 the Trust and Mr C agreed to leave UR1, LL1, LL2 and LR1 in place. Mr C had mistakenly referred to this as three teeth on the lower left side. However, it was in fact two teeth on the lower left side and one on the lower right side, plus one tooth on the upper right side. The records showed that he later agreed to the extraction of UR1. But, up to spring 2013 the records showed that his dental plan was to leave LL1, LL2 and LR1 in place.

We found there was no clinical note for spring 2013 to support the Trust's comments about this consultation. Therefore, we could not confirm what was discussed and agreed between the surgeon and Mr C. We could not confirm whether Mr C consented to the clearance of his teeth as the surgeon stated.

Although we did not have a record for the extractions in spring 2013, the evidence indicated that the surgeon did not follow the original dental plan and on balance the surgeon extracted the teeth outside of the treatment plan without gaining proper consent. This was a failing.

However, we could not link this failing to all of the injustice Mr C claimed, but it was Mr C's right to retain the teeth if that is what he wanted to do. Furthermore, the dentures had already been constructed to fit around the three teeth that were going to be left in place. Therefore, his denture did not fit. Overall the failings led to distress and inconvenience for Mr C.

Putting it right

The Trust apologised for the failings we identified and for the distress Mr C experienced because of them. It also paid him £750 in recognition of the impact of these failings on him.

The Trust explained what it had learned from the failings we identified so that they would not happen again.

Organisation(s) we investigated

Shrewsbury and Telford Hospital NHS Trust

Location

Shropshire

Region

West Midlands

Summary 1141/October 2015

Failure to provide adequate pain relief and pressure mattress

Mrs G was not happy with the care and treatment that two trusts gave her husband. She said this left her emotionally distressed and she felt let down by the responses she received from both of them.

What happened

Early one morning in spring 2014, Mr G woke up complaining of shortness of breath and chest pain. He also vomited. Mr G had a longstanding heart complaint, but he rarely vomited. His family phoned for an emergency ambulance. The ambulance crew took observations and they were all normal apart from a low temperature and an absence of bowel sounds. The ambulance crew decided that Mr G had an allergy and advised him to take paracetamol and to rest. They said that if there was no improvement he should see his GP. They offered to take Mr G to hospital, but felt he did not need to go. Mr G opted to stay at home.

After the ambulance crew left, Mr G's condition worsened and he vomited mucous. His family took him to the Trust and he was admitted with sepsis of an unknown source and an absence of bowel sounds.

Mr G was sent to a medical assessment unit and remained there until late evening. He was eventually transferred to a side room in a ward. Mr G's family were not happy with the care he was getting and so temporarily employed their own carer who, along with Mrs G, stayed with him during the last few days of his life. Mr G's health deteriorated and he died three days later. The cause of his death was sepsis arising from an ischaemic bowel (when an artery that supplies blood to the large and small intestines becomes blocked or narrowed), secondary to severe chronic heart disease.

Mrs G's daughter complained to the Trust about poor nursing care that caused the family to employ their own carer. Mrs G requested her husband's medical records because she was concerned that there were significant omissions in the treatment her husband received. She found out from the medical records that the decision not to attempt cardiopulmonary resuscitation (DNA CPR) had been made about her husband without her knowledge. She submitted further complaints to the Trust including about inadequate pain control, delay in receiving an air mattress, poor nursing care and the attitude of nurses.

What we found

We partly upheld the complaint about the Trust. While we found no explicit mention of Mrs G being informed about the DNA CPR decision, there was ample evidence to show that consultants from three disciplines advised her on the dire condition of her husband.

Our clinical adviser said that the treatment Mr G received at the Trust accorded with good practice. The diagnosis of an ischaemic bowel is usually a surgical diagnosis based on clinical features and supported by lab tests and imaging. There were no obvious omissions in the treatment he received.

The Trust acknowledged that nursing care had fallen below the standard it would expect. It had already apologised to Mrs G and provided details of improvements made in these areas.

However, we felt that the Trust had not satisfactorily explained why a doctor did not see Mr G when he reported that he was experiencing great pain and there were delays before he received an air mattress.

Putting it right

The Trust acknowledged and apologised for the failings we identified. It also gave Mrs G details of improvements made in its provision of air mattresses.

Organisation(s) we investigated

Milton Keynes Hospital NHS Foundation Trust

Location

Buckinghamshire

Region

South East

Summary 1142/October 2015

District nurses failed to ensure that a pressure relieving cushion was safe for dementia patient

Mr Y said district nurses were responsible for his late mother, Mrs Y, falling from her chair which led to a decline in her health.

What happened

Mrs Y lived alone and had vascular dementia and mobility problems. A homecare agency and her grandson were her carers. District nurses from the Trust also visited her at home as part of a community care plan.

When Mrs Y developed significant pressure ulcers, district nurses started to treat and dress them. They noted she could move '*with limited assistance*' but her ankles were very swollen. They planned to order a pressure relieving cushion. They faxed an order for the cushion, noting that staff should call Mrs Y's grandson before they delivered it. This order was not signed. The district nurses continued to visit over the following days and noted Mrs Y's pressure ulcers were improving. A few days later, the district nurses had to reorder the cushion because it had not yet arrived. They sent the same form but this time signed the document.

The cushion was delivered to Mrs Y during the afternoon. The signatures of both the person ordering the cushion and the person receiving it were unclear. The records showed that someone phoned Mrs Y's grandson but there was no reply. Shortly afterwards Mrs Y's carer found her on the floor by her chair. Mrs Y said she had fallen from the cushion.

Mr Y complained that district nurses put the cushion on his mother's chair. He said they should have contacted his son first as agreed when nurses planned the delivery. He said his mother suffered from worsening health following the incident. Mr Y was also unhappy with the Trust's complaint handling.

What we found

We partly upheld this complaint. We found that district nurses did not follow the relevant guidelines and established good practice. They should not have allowed the cushion to be delivered when they were not present. They should also have contacted Mrs Y's grandson as had been agreed, which they failed to do.

We did not conclude that Mrs Y fell from the cushion. This was because there were no witnesses and Mrs Y suffered from dementia. There was no evidence that district nurses went to see Mrs Y on the day the cushion was delivered. Mrs Y already had significant medical problems at the time of the incident. We could not say that the failings led to any decline in her health.

We did not find failings in complaint handling.

Putting it right

The Trust had already apologised for its failings. But it accepted our recommendation and produced an action plan to show that it had learned from the complaint.

Organisation(s) we investigated

Staffordshire and Stoke on Trent Partnership NHS Trust

Location

Staffordshire

Region

West Midlands

Summary 1143/October 2015

GP practice unfairly denied patient a home visit

Mr J needed a new prescription for diazepam (used to treat anxiety disorders) and inhalers. He asked if the Practice could carry out a home visit, but it refused to do so. As a result, he suffered from breathing difficulties and a panic attack. He also complained about the Practice's and NHS England's poor complaint handling.

What happened

Mr J was a new patient at the Practice. When he registered, his carer informed staff that he was agoraphobic (an anxiety disorder) and had difficulty leaving the house. The Practice's policy for home visits was that '*Home visits are only for those who are housebound or too ill to come to surgery*'. The Practice noted, at the time, that Mr J was '*housebound due to panic attacks*'.

Mr J's carer booked him an appointment at the Practice so that his prescriptions could be renewed. However, two days before the appointment Mr J felt that he would not be able to attend. His therapist discussed this with the Practice but it decided that Mr J could come to the Practice. This was because before his appointment, the Practice reviewed Mr J's condition and noted that there had been occasions when he had left the house to visit a local shop. The GP who Mr J was scheduled to see therefore concluded that Mr J was neither housebound nor too ill to come to the Practice and that a home visit was not necessary.

Mr J suffered a panic attack and was seen at home by an out-of-hours doctor who renewed his prescriptions. His carer complained to NHS England on his behalf. NHS England responded saying that it considered that '*appropriate care and treatment*' had been provided, and although the Practice declined to carry out a home visit, '*consultations had been offered by telephone*'. Mr J's carer was unhappy with the response.

What we found

We partly upheld this complaint about the Practice and NHS England. We found that although the decision to carry out a home visit was discretionary, the Practice's policy was to visit patients at home if they were '*housebound*'. We found that the evidence did not show that Mr J was not housebound, and therefore the Practice applied its policy unfairly by deciding not to visit him.

We also found that the Practice did not respond to the complaint appropriately as it did not explain the reason why it declined to carry out a home visit.

With regard to NHS England, we found that its investigation did not address the points that it had agreed to look into at the outset.

Putting it right

The Practice apologised to Mr J for the failure to apply its policy regarding home visits fairly. It also introduced measures to make sure that staff were applying the policy fairly when requests for home visits were received.

NHS England apologised for the failure to properly investigate the complaint.

Organisation(s) we investigated

A GP practice

NHS England

Location

Derbyshire

Region

East Midlands

Summary 1144/October 2015

Trust did not give adequate care to older patient

Mrs D's family complained that the Trust failed to give her appropriate care and treatment. They raised concerns about her nutrition and lack of dignity with regard to failure to wash her and provide clean sheets.

What happened

Mrs D was in her late eighties and cared for by her daughter, Mrs N. She had a number of medical conditions. In late 2013, an ambulance took Mrs D to hospital after she had been unwell for four days. The A&E records showed she was sleepy and tired all the time, had abdominal pain and had not been eating. Her family understood from a GP that she would be admitted to hospital for 48 hours to receive intravenous antibiotics. In hospital she was diagnosed with a chest infection and she was admitted and treated with antibiotics and fluids. The family wanted Mrs D to be cared for at home if it was thought that no more could be done for her. She was actively treated in hospital for ten days and was then discharged home. She died two days after this.

Mrs N complained that following admission for abdominal pain, no appetite and general ill health, Mrs D developed septicaemia. She said this was caused by the lack of treatment she received while an inpatient at the Trust. Mrs N also said Mrs D was not cleaned or bathed during her time at the Trust. She said she was not fed and her arms were bruised due to multiple unsuccessful attempts to introduce antibiotics intravenously.

Mrs N felt this showed neglect. Mrs N also complained that there were failings in pressure care and catheter care.

Mrs N said she and the immediate family had been left traumatised at having to watch Mrs D deteriorate and then pass away. She wanted explanations and to know what the Trust had done to prevent the issues they experienced happening to anyone else. She also wanted a consolatory payment to put towards funeral expenses.

What we found

We partly upheld this complaint. We found the Trust's management of Mrs D's clinical care with regard to infection was appropriate. However, incomplete records meant we could not say whether Mrs D was offered assistance to eat at each mealtime, or whether, had more encouragement been given by staff, she would have eaten more, given that she was so poorly. Importantly, any lack of nutrition over the short time frame was unlikely to have made a difference to the sad outcome.

We found that Mrs D's poor condition caused her body, especially her arms, to fill with fluid, causing problems with the intravenous cannulas and the taking of blood samples. Nursing records noted that a bed bath was given on an almost daily basis, an exception being when Mrs D requested that she have only a basic wash. Mrs D was given a new gown and bed linen was changed. It was also appropriate to actively treat Mrs D in hospital for ten days and there was no evidence of obstacles or delays in her being sent home.

The Trust had acknowledged some failings and apologised to Mrs D's family before the complaint came to us. It said a pressure mattress should have been given to Mrs D and that doctors looking after Mrs D did not communicate with her or the family about a diagnosis or the treatment being provided.

It apologised for catheter not being changed promptly and for the additional upset or distress this caused Mrs D. However, it did not give information about the actions taken to prevent these failings from happening again.

Putting it right

The Trust wrote to Mrs N and gave her information about service improvements in the areas we identified failings. It also paid her £1,250 in recognition of the distress and upset these failings caused.

Organisation(s) we investigated

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust

Location

North Lincolnshire

Region

Yorkshire and the Humber

Summary 1145/October 2015

Communication about labour should have been better

Mrs E said the Trust gave her poor maternity and postnatal care.

What happened

In autumn 2012 Mrs E went to the Trust's maternity assessment unit with concerns about reduction in her baby's movements. The midwife took a full history and carried out a cardiotocograph (recording of foetal heartbeat). The midwife reassured Mrs E that labour was not established and she returned home. Three days later Mrs E went to the Trust's birthing centre because her waters had broken. In the morning the Trust transferred her to the delivery suite due to concerns about the baby's heart rate and labour not progressing. Mrs E had her baby later that day by forceps delivery.

In autumn 2013 Mrs E complained to the Trust about a number of issues. She said that Trust staff did not take seriously her concerns about being able to cope with childbirth due to her petite size, that she was not given adequate pain relief, that staff suggested that she should return home in the early hours, that staff did not move her earlier to the delivery suite, that there was a lack of empathy from staff, and about her experience in the birthing centre. She said she received poor midwifery care, which had affected her emotionally and financially, she developed postnatal depression and was unable to physically care for her son. She also said she became estranged from her family and had an injury (cervical tear) that may cause a miscarriage in the future.

The Trust acknowledged most of the failings and apologised that Mr and Mrs E were dissatisfied with the service given and that it did not meet their expectations. It also expressed its unreserved apology for the distress and anxiety this caused them and it addressed many of Mrs E's concerns at the local meeting.

Mrs E was not satisfied with the Trust's response. She wanted an acknowledgement of failings and a consolatory payment.

What we found

We partly upheld this complaint. We found no clinical evidence to suggest that Mrs E had a problem giving birth because of her petite size. The Trust acknowledged that communication, which had the aim of reassuring Mrs E about this, may not have been adequate, and it apologised for this. This was an appropriate thing to do in the circumstances.

We found there were some failings in the birthing centre. The Trust did not keep Mrs E informed about the care plan and the positioning of a birthing couch. However, it had already acknowledged this and apologised.

We found that overall the midwifery care and treatment, including pain relief, was appropriate. But communication about the latent phase of labour (before labour is fully established with regular painful contractions) should have been better and may have allowed Mrs E to feel in more control of her labour. The Trust had not acknowledged this.

Putting it right

The Trust acknowledged and apologised for the poor communication. It also took steps to improve this.

Organisation(s) we investigated

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 1146/October 2015

Unacceptable delay in responding to a complaint

Mrs P complained that the Trust delayed investigating and treating her pneumonia. She also raised concerns about how she was discharged and the length of time the Trust took to respond to her complaint.

What happened

Mrs P, who was in her early eighties, was admitted to the Trust in autumn 2013 at around 1pm, with suspected pneumonia. A medical team reviewed her and investigations about her condition were carried out. These included, a chest X-ray, an ECG (electrocardiogram to check heart's rhythm and electrical activity), and blood tests.

Five hours later, Mrs P started to struggle with her breathing, and her daughter, Mrs Q, made staff aware of this. Mrs Q was also concerned that her mother had not yet been given any medication or treatment. Staff reviewed Mrs P's blood test results after Mrs Q raised concerns. Mrs P was diagnosed with pneumonia and prescribed intravenous antibiotics. However, staff delayed administering the antibiotics immediately because they thought the antibiotics were due two hours later.

Mrs P stayed in hospital, completing a five-day course of antibiotics before being discharged home. In the days after her discharge, Mrs Q became concerned about Mrs P's condition and sought help from Mrs P's GP. The GP prescribed Mrs P some further antibiotics and her condition gradually improved.

Mrs P and her daughter complained to the Trust in autumn 2013 but did not receive a response to their complaint until early 2015. Mrs P and Mrs Q said the Trust should not have discharged Mrs P with an active infection without any medication. Mrs P said she suffered distress as a result of her life being put at unnecessary risk and her having to seek further medical help from her GP after the Trust discharged her.

The Trust apologised for the delay in responding to the complaint but Mrs P remained unhappy and came to us. She wanted the Trust to improve its service to make sure that other patients did not have a similar experience.

What we found

We partly upheld this complaint. We found that there was not an unreasonable delay in Mrs P's condition being investigated and treated. The Trust's decision to discharge her was in line with established good practice, as was the decision not to provide any additional antibiotics.

However, the length of time the Trust took to respond to the complaint was unacceptable and was a failing. Therefore, we upheld this part of the complaint.

Putting it right

The Trust produced an action plan showing steps it had taken to make sure that complaints were responded to in a timely manner and so similar delays would not happen again.

Organisation(s) we investigated

United Lincolnshire Hospitals NHS Trust

Location

Lincolnshire

Region

East Midlands

Summary 1147/October 2015

Trust delayed diagnosing septicaemia and family will never know if outcome could have been different

After Mr B's bowel operation, the Trust failed to monitor his fluid intake, did not update his medical records, delayed dialysis treatment, did not carry out appropriate blood tests and failed to diagnose septicaemia. This caused Mr B's family considerable distress.

What happened

A 3cm tumour was found in Mr B's rectum and he was admitted to hospital for an operation to remove it. During the operation, Mr B's spleen was torn. Repair was attempted but the spleen had to be removed. Because of the unplanned removal of his spleen, Mr B was cared for in the high dependency unit (HDU). He was later moved to a ward.

However, Mr B's wife, Mrs B, said he began to deteriorate on the ward. The Trust recorded that he had reduced urine output, ileus (failure in the movements of bowel muscle), and increased pain. It also recorded that there was an episode of loss of consciousness and staff had called the cardiology team when Mr B suffered a cardiac arrest. Mr B was transferred back to the HDU and suffered another cardiac arrest ten minutes after arrival and vomited. During resuscitation significant aspiration of vomit occurred (vomit went to his lungs).

Mr B died in hospital a few weeks later. The cause of death was recorded as multi-organ failure, pneumonia leading to septicaemia, and recent rectal cancer with postoperative gastric aspiration.

Mr B's family complained to the Trust about Mr B's care and treatment. Mr s B said the Trust failed to diagnose septicaemia, monitor his fluid intake and update his records. She believed that had Mr B received the correct care, he would have been treated successfully and would not have died. The Trust carried out a root cause analysis into Mr B's care, which recognised a number of concerns and made a number of recommendations.

But Mrs B remained unhappy with the Trust's response and wanted the Trust to make service improvements so that the situation the family experienced would not happen to anyone else. She also wanted a consolatory payment.

What we found

We partly upheld this complaint. We found injury of the spleen was a recognised complication associated with the surgery that Mr B had, and does not mean his care was unreasonable. Therefore, removal of the spleen did not contribute to the sad outcome.

The Trust acknowledged fluid charts were not completed postoperatively, that nursing records were not complete and the required level of monitoring and assessment was not carried out, and it took action to address this. It also recognised that a consultant should have reviewed Mr B after a junior doctor requested this.

We found that if appropriate blood tests had been taken, the results may have identified Mr B as a high risk patient, prone to developing postoperative complications and that therefore, he might have benefitted from a high dependency/intensive care monitoring rather than being cared for on the ward. The Trust should also have considered siting a nasogastric tube (NG – feeding tube that is passed into the stomach via the nose) but we could not say had one been sited that it would have prevented Mr B developing aspirational pneumonia.

While Mr B was on appropriate antibiotics both before and after his transfer to HDU, there was a delay in diagnosis and other appropriate treatment regarding impending septicaemia. However, we could not say whether the outcome for Mr B would have been different if all of the above had taken place.

Putting it right

The Trust acknowledged and apologised to Mrs B that there was a missed opportunity to begin treatment earlier due to a delay in diagnosing septicaemia. It also apologised that siting an NG tube was not considered following an episode of vomiting.

The Trust paid Mrs B £1,000 in recognition of the upset and concern caused by the failings we and the Trust identified.

Organisation(s) we investigated

County Durham and Darlington NHS Foundation Trust

Location

County Durham

Region

North East

Summary 1148/October 2015

A member of the British Armed Forces and his wife denied NHS-funded IVF treatment

Mr H complained that he and his wife were told by a hospital trust that they were not eligible for NHS-funded IVF treatment, even though they should have qualified for this treatment under NHS England's commissioning policy.

What happened

In late 2013, Mr and Mrs H went to see a consultant gynaecologist (the Consultant) at the Trust to discuss fertility treatment. The Consultant advised them that, because Mrs H was 42 years of age, she was not eligible for NHS-funded IVF treatment under the local clinical commissioning group's policy and that self-funded IVF treatment was their only option. Mr and Mrs H felt that the way the Consultant delivered this information was rude.

The Consultant did not tell them that they could apply for NHS funding under a separate NHS England commissioning policy for serving members of the British Armed Forces because she was not aware of it. The policy extended the age limit for women up to 43 (Mrs H would have turned 43 in summer 2014).

Mr and Mrs H sought help for self-funded IVF treatment. Around summer 2014, a military charity informed them that, as a serving member of the British Armed Forces, Mr H should have qualified for NHS-funded IVF treatment under the NHS England commissioning policy. By the time that information was given, Mrs H had turned 43, which was the age limit to qualify for NHS-funded IVF treatment under that policy.

What we found

We partly upheld this complaint. We did not find any failings on the part of NHS England. However, we found failings on the part of the Trust.

We had no independent evidence to reconcile the differing recollections of the Consultant, and Mr and Mrs H, in respect of the way the Consultant conducted herself at the appointment. But we found that NHS England had appropriately informed the Trust's medical director about the commissioning policy in an email sent to him in autumn 2013. We concluded that the Trust should have followed its usual procedure to share the information contained within the email with its staff. Because this did not happen, we found that was a failing by the Trust.

Mr H was smoking e-cigarettes at the time of the appointment, which would have precluded him from NHS-funded IVF treatment under NHS England's commissioning policy. Had he been made aware of that policy, we considered it was more likely than not he would have been able to stop smoking before Mrs H turned 43, especially given that he had done so in order to undergo self-funded IVF treatment. We found that this meant that Mr and Mrs H would have qualified for NHS-funded treatment under NHS England's commissioning policy were it not for the failings of the Trust.

We concluded that the opportunity for Mr and Mrs H to take the above steps was lost. We found that it would have been distressing and frustrating for Mr and Mrs H to later discover they should have been informed of NHS England's commissioning policy, by which time Mrs H was no longer eligible because of her age. This would have further compounded the distress already suffered.

We could not say whether Mrs H would have conceived had she received NHS-funded IVF treatment in mid-2014. What we could say was that because the chances of conception diminish with age, Mr and Mrs H were left not knowing if the outcome could have been different. We had no doubt that this would be a continued source of distress to them.

Putting it right

The Trust acknowledged the failings we identified and apologised to Mr and Mrs H. It also reimbursed them the cost of the round of IVF treatment that the NHS should have given them, and a further payment of £1,000 for the distress caused to them. The Trust reviewed its communication policies and produced an action plan to prevent similar failings happening again.

Organisation(s) we investigated

Gloucestershire Hospitals NHS Foundation Trust

NHS England

Location

Gloucestershire

Region

South West

Summary 1149/October 2015

Patient was discharged from A&E without proper diagnosis

Mrs Y went to A&E but was wrongly diagnosed with a urinary tract infection and needed surgery at a different hospital 24 hours later, for an obstructed bowel.

What happened

Mrs Y was ill on holiday and went to A&E. The initial impression was that she may have had gallstones (which she had suffered from the previous year). However, she was subsequently told she had a urinary tract infection and was discharged without any medication. The next day she went to her local hospital and needed an emergency operation because her bowel was obstructed by gallstones.

Mrs Y's friend, Mr W, (who she had been on holiday with) complained to the Trust because he said she experienced 24 hours of unnecessary, dreadful pain and anxiety, which had also caused worry for her friends and family. In response the Trust said that there was no indication Mrs Y had gallstones and that the diagnosis of a urinary tract infection was reasonable under the circumstances. Mr W was unhappy and he and Mrs Y asked us to investigate the complaint.

What we found

We upheld the complaint. Our medical adviser told us that Mrs Y should have had a further examination before any discharge decision was made and that this should have been fully documented. The Trust told us that the A&E doctor had not documented anything after the initial assessment of Mrs Y. Our medical adviser told us this was a significant shortcoming. He also told us that, based on the information that was available, while the doctor's initial impression was reasonable, the decision to discharge Mrs Y with a urinary tract infection could not be supported.

Putting it right

The Trust acknowledged the failings we identified and apologised to Mrs Y. It also paid her £125 in recognition of the unnecessary discomfort and anxiety she experienced before her condition was correctly identified and treated.

Organisation(s) we investigated

Royal Devon and Exeter NHS Foundation Trust

Location

Devon

Region

South West

Summary 1150/October 2015

Man received no treatment and waited nearly nine hours for a hospital bed, before he collapsed and died

Ms R complained that her brother, Mr P, arrived in the acute medical unit (AMU) and after a nine-hour wait, he became unconscious and later passed away. She was unhappy that his symptoms were not taken into consideration and believed that had he received the correct care, he would have been successfully treated.

What happened

Mr P was seen at an NHS walk-in centre complaining of shortness of breath and chest pains. The centre referred him for further assessment at the Trust and he was taken there by ambulance. A triage nurse saw him in the AMU just after 5pm. A junior doctor saw him at 6pm and considered that Mr P had pneumonia. As there was no bed available, Mr P remained in the foyer of the AMU. He was transferred to a bed at nearly 2am. Shortly after this, Mr P collapsed and could not be resuscitated. A post mortem examination showed a large lung abscess with a collection of pus, and a large pleural effusion (a build-up of fluid between the lining of the lungs and the chest cavity).

Ms R complained to the Trust. She believed her brother had died unnecessarily, and had the Trust acted sooner he would still be alive.

The Trust acknowledged that Mr P had waited several hours in the foyer area, which it said was not ideal, and apologised for this. However, it said that Mr P's lung problem had been ongoing for some time and that he would have continued to deteriorate, and would likely have died as a result of the advanced infection in the lung. The Trust said that the junior doctor involved had been made aware that he should have discussed Mr P's case with a more senior doctor. It also said that it was actively working towards having more senior cover, aiming for two consultants on duty each evening.

What we found

We upheld this complaint. We found that, despite worrying observations on admission, Mr P was left in a non-clinical area and received no care of note. The doctor who saw him failed to appreciate the potential severity of his condition, and did not call for any immediate treatment, especially antibiotics, despite clinically reaching the correct diagnosis of pneumonia. We considered the lack of care reflected the whole situation affecting the hospital at that time. Mr P was not admitted to a bed earlier because there was no bed available. He did not receive a senior clinical opinion soon enough because the senior doctor was otherwise occupied, which left the junior doctor as the sole person to see Mr P, with no senior back up to pick up on the error promptly.

We considered that, given his advanced infection, Mr P may well have died even with treatment. However, we found that the care the Trust gave him placed him at significantly increased risk of a poor outcome.

Putting it right

The Trust acknowledged its failings and apologised to Ms R. It paid her £1,000 in recognition of the distress caused to her by the failings in her brother's care. The Trust also produced an action plan to show how it had learned from its mistakes so that they wouldn't happen again.

Organisation(s) we investigated

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Location

Liverpool

Region

North West

Summary 1151/October 2015

Patient mistakenly given cancer all clear

The Trust did not use the right technique to test Ms T's biopsies in summer and autumn 2013, which meant that her cancer was misdiagnosed as cervical cancer. Following a hysterectomy, she was wrongly given the all clear. The Trust also failed to acknowledge Ms T's complaint and delayed responding to it.

What happened

Ms T, in her early twenties underwent a colonoscopy (examination of the inner lining of the larger intestine) and biopsy of her cervix in spring 2013. The tissue sample showed an abnormality so the Trust took further biopsies in summer 2013. Ms T was diagnosed with cancer of the cervix. This was confirmed at a regional laboratory around the same time in 2013. She had a hysterectomy shortly after that and was given the all clear. Ms T had a further biopsy in late 2013 and no issues were detected.

Due to health issues, Ms T had a lung biopsy in early spring 2014 and again no issues were detected. However, due to other test results including a CT scan, the Trust referred her to a specialist cancer centre. Ms T underwent a more detailed biopsy and the results were reviewed along with the earlier biopsies using a different technique. These showed that Ms T's lung lesions were cancer that had spread from her cervical cancer, which turned out to be neuroendocrine cancer (rare tumours in the nerve and gland cells) and not cervical cancer as originally reported.

Ms T complained to the Trust in summer 2014. The Trust responded saying that its pathologists followed correct procedures at the time and that Ms T's cancer was uncommon and its pathological presentation was unusual. This made early diagnosis of her cancer difficult. However, it had shared lessons from Ms T's experience with its pathologists and it would use a special staining technique on biopsies such as hers in the future.

Unfortunately, Ms T died in autumn 2014. Ms K complained to us on behalf of her late friend.

What we found

We partly upheld this complaint. We obtained advice from a specialist clinical adviser. We found that the Trust used an appropriate technique for examining Ms T's biopsy samples, which was consistent with the relevant guidance. In addition, her tissue samples were examined by the Trust's pathologists and were also sent to the regional specialist laboratory for a central review. This was the accepted usual practice and was appropriate. Therefore, while the initial diagnosis was later proved to be wrong, the evidence showed that the Trust used an appropriate technique for examining the samples and followed the proper protocol by sending them to a regional centre to have the results confirmed.

With regard to the Trust's complaint handling we found that there was a two-week delay from the date Ms T's letter was dated (mid- summer 2014 and it being received by the Trust. However, from the point it was received the Trust intended to respond a month later. This was an appropriate time frame. But the actual response was not sent out until end of summer 2014. This was slightly under six weeks. The Trust explained that the complaint had taken longer to respond to because of its complexity and the need for the views of several staff. The Trust's explanation was reasonable in our view. We did not find that the delay in responding was sufficient to be a failing but it was very unfortunate due to the high sensitivity of the circumstances.

This was compounded because Ms T did not receive an acknowledgement that her complaint had been received, or an explanation of what the Trust's investigation time frame was. Additionally, the Trust's response letter did not explain what Ms T's next steps were if she was dissatisfied with it's response. In our view these were failings that added to Ms T's distress.

Putting it right

The Trust apologised to Ms K and Ms T's parents for the failings we identified. It also produced an action plan to show what it had learned from the failing to prevent them happening again.

Organisation(s) we investigated

Great Western Hospitals NHS Foundation Trust

Location

Swindon

Region

South West

Summary 1152/October 2015

Trust failed to identify a displaced wrist fracture, which led to the fracture healing in an abnormal position

Mrs H complained that her fractured wrist did not heal correctly because of failings in the treatment that she received from the Trust. She said as a result she was left with a misaligned wrist, which resulted in a lack of movement and this impacted greatly on her ability to complete everyday tasks. Mrs H wanted service improvements and a payment.

What happened

Mrs H fell at home in late 2012 and hurt her wrist and ankle. She went to A&E at the Trust, where an X-ray identified a fractured wrist. The Trust manipulated the bone back into position and applied a plaster cast.

Mrs H went to the fracture clinic 12 days later and a further X-ray was taken. A hard cast was applied and a further appointment was scheduled for four weeks' time.

The cast was removed and Mrs H felt that the wrist was not in the correct position. However, the consultant felt that her wrist was simply swollen so made a further appointment for the following week. At this stage Mrs H requested another X-ray and this revealed that the fracture had healed but in an abnormal position (malunion). She underwent physiotherapy and hand therapy. The Trust offered Mrs H an operation to try to realign her wrist but she declined because she was told that it was unlikely to give her any more movement than she already had.

Mrs H complained to the Trust, raising concerns about the care she had been given. She detailed the impact which this had on her life and her inability to carry out activities. The Trust expressed regret for Mrs H's situation and explained that malunion was a known, but rare, complication and was not an indication of poor treatment.

Mrs H was not satisfied with the Trust's response and complained to us.

What we found

We upheld this complaint. We found that because of the nature of Mrs H's fracture, an appointment should have been given in the fracture clinic within a week of the initial injury. When Mrs H went to the Trust 12 days later, the X-rays showed that the fracture had returned to the position that it had started in late 2012 before the manipulation. Therefore, it was clear at that stage that the Trust should have recognised that the position obtained by the manipulation had been lost and because of the nature of the fracture it was likely to slip further. The Trust should not have simply made an appointment for four weeks' time when it was likely that the fracture would have been united. A simple surgical intervention should have taken place.

As a result, Mrs H's wrist healed in an abnormal position, which resulted in a loss of movement that affected her ability to conduct daily tasks. We considered that if the correct treatment had been given, while the movement in the wrist would not have been 100%, it was likely to have been significantly improved and the appearance of Mrs H's wrist more likely to have been normal.

Putting it right

The Trust paid Mrs H £1,000 in recognition of the impact the failings we identified had on her. It also produced an action plan to show it had implemented service improvements.

Organisation(s) we investigated

Western Sussex Hospitals NHS Foundation Trust

Location

West Sussex

Region

South East

Summary 1153/October 2015

Woman wrongly denied funding for breast reconstruction after cancer treatment

A woman's request for breast surgery was deemed to be cosmetic, even though her asymmetry (unevenness) was a result of cancer treatment.

What happened

Mrs B had breast cancer in 1999, which was successfully treated with surgery, chemotherapy, radiotherapy and lymph node removal. Over the years Mrs B's breasts became increasingly asymmetrical due to complications from the radiotherapy and lymph node removal.

Mrs B was not offered reconstructive surgery at the time of her cancer treatment and it was not discussed with her until a follow-up appointment in 2012, at a breast clinic. However, on the day of the preoperative appointment she was told that she would need to apply for funding for her surgery. Mrs B's GP applied to her local primary care trust (PCT) but the request was declined on the basis that the procedure was considered to be cosmetic rather than reconstructive due to the length of time that had passed since her cancer treatment. Mrs B's GP appealed the decision but this was unsuccessful.

Mrs B saved up and had her surgery privately. She then complained to the Clinical Commissioning Group (CCG - who had taken over from the PCT in funding matters) but the CCG upheld the PCTs original decision.

Mrs B said that due to the CCG's refusal she had to pay for private surgery at a cost of over £6,000. Mrs B said she had also suffered emotional distress due to the CCG's decision. She wanted payment for the cost of the surgery.

What we found

We upheld Mrs B's. We found that the PCT and CCG were wrong to classify Mrs B's surgery as cosmetic. Her breast asymmetry was a direct result of her breast cancer treatment. The PCT had failed to take into account the clinical information and advice that was available at the time, that Mrs B's condition was a progressive one that worsened over time. There was no time limit on reconstructive surgery and we found that it was unfair to decline to fund Mrs B's request.

Putting it right

The CCG apologised to Mrs B and refunded the cost of her surgery.

Organisation(s) we investigated

North Lincolnshire Clinical Commissioning Group (CCG)

Location

Lincolnshire

Region

East Midlands

Summary 1154/October 2015

Trust failed to check results of patient's X-ray before discharging him

As a result of the Trust not reviewing a patient's chest X-ray before discharging him, and not following him up, it delayed diagnosing that he had cancer.

What happened

Mr J had had a bad cough for two months when he was admitted to the Trust in summer 2014. He had a chest X-ray and as the Trust suspected a chest infection he was given intravenous antibiotics, and then discharged.

Mr J remained unwell and he was readmitted to the Trust for further tests around the same time. A further chest X-ray was carried out and the clinician also looked at the first X-ray results. The further test results showed that he had lung cancer.

The Trust decided Mr J's cancer was too widespread to treat because he was not well enough to undergo aggressive radiotherapy and chemotherapy. He was discharged home at the request of his family in late summer, to have palliative care. His condition deteriorated and he was readmitted to the Trust. He died shortly after that.

Mr J's son, Mr M, complained about the care and treatment his father received from the Trust in relation to diagnosis and treatment of his cancer. Mr M believed his father's life had been shortened. He said he and his family were deprived of time with his father, and felt let down by the NHS.

The Trust said that Mr M's father's cancer had been well advanced when he was admitted in summer 2014, and that even then he was not well enough to have tolerated the anticancer treatments. As such, while the diagnosis could have been made six weeks earlier, this would not have lengthened his life. The Trust apologised because it acknowledged that an earlier diagnosis would have allowed Mr M's father more time to get his affairs in order and spend quality time with his family. Mr M accepted £400 from the Trust in recognition of the errors it had made. He remained dissatisfied with the Trust's response and brought his complaint to us.

What we found

We upheld the complaint. We found that although Mr J's cancer could have been diagnosed earlier, this would not have affected the outcome for him because his lung cancer was already too far advanced even in summer 2014.

However, we found that in not reviewing the first X-ray, or giving Mr J a follow-up appointment, the care the Trust gave him was not in line with recognised quality standards and established good practice. This deprived Mr J's family of extra time to plan for the end of his life in a more well-informed way.

Putting it right

Mr M did not want the Trust to write to him to apologise.

Instead the Trust accepted our recommendation and prepared an action plan to make sure lessons were learned from these failings and to prevent them happening again.

Organisation(s) we investigated

Calderdale and Huddersfield NHS Foundation Trust

Location

West Yorkshire

Region

Yorkshire and the Humber

Summary 1155/October 2015

Delays in treatment and poor communication caused distress

Mr T complained about the care and treatment given to his father, Mr K, between spring 2012 and early 2013 when he was being treated for bladder cancer. He said the Trust did not offer his late father treatments that could have relieved his pain and possibly prevented his death.

What happened

Mr K was diagnosed in 2007 with cancer of the bladder for which he was given treatment and also had regular check-ups to monitor his condition. Mr T did not complain about the treatment given to Mr K before spring 2012.

Mr T said that in spring 2012 Mr K had a cystoscopy alongside other tests, which showed that the cancer may have recurred. A cystoscopy is a medical procedure used to examine the inside of the bladder. He had a follow-up cystoscopy in autumn 2012 and biopsies of the bladder were also taken, which showed evidence of bladder cancer. A month later, because of Mr K's age and overall health, the Trust found him to be unfit for the ideal surgical treatment of cystoscopy with urinary diversion (surgical procedures to reroute urine flow from its normal pathway). However, Mr K's symptoms continued to worsen and in early 2013 he underwent a urinary diversion procedure to relieve his symptoms. Mr K passed away in spring 2013.

Mr T complained to the Trust that it delayed to carry out a follow-up cystoscopy from spring 2012 until autumn 2012. This delay meant precious months were lost in the identification and possible treatment of the developing cancer. He also raised concern that following the cystoscopy in autumn 2012, the Trust did not take action to help his father '*despite his extreme pain, dire quality of life and life-threatening condition*'. He said his father was not assessed for possible surgery until late 2012 and his bladder was not assessed to establish the state of the cancer when he was discharged from hospital. He also complained about the Trust's poor communication.

Mr T said his father died following months of severe pain and distress due to the inaction and negligence of the Trust. He wanted full acknowledgements, a formal apology, service improvements and a payment for the distress caused to him and his mother at witnessing the pain and distress of his father.

What we found

We partly upheld this complaint. We found that after Mr K had a cystoscopy in spring 2012, there was a delay of approximately one month in conducting the follow-up cystoscopy. The Trust apologised for this, which we found to be reasonable, as we did not see that the delay made any difference to Mr K's prognosis.

We found that the Trust should have conducted a urinary diversion procedure more quickly than it did, in the context of Mr K's worsening symptoms. We also found the Trust's communication with Mr K to be poor, particularly following the autumn 2012 cystoscopy. We did not find any failings relating to the Trust's care and treatment in the period following Mr K's urinary diversion operation.

Putting it right

The Trust apologised to Mr T and paid Mr K's wife £350 in recognition of the distress caused to her at witnessing her husband's pain and discomfort. It also produced an action plan explaining what it had learned from the failings we identified and what it had done to avoid a recurrence of the failings.

Organisation(s) we investigated

Royal Devon and Exeter NHS Foundation Trust

Location

Devon

Region

South West

Summary 1156/November 2015

Delayed MRI scan, but this didn't cause death

Brain scan took longer than guidance recommends, but did not change the outcome for Mr B.

What happened

In early 2012 Mr B lost consciousness and collapsed. An ambulance was called, but by the time it arrived Mr B had regained consciousness. The ambulance crew thought he had fainted and did not take him to hospital.

The next week Mr B went to see his GP who referred him to the Trust's neurology outpatient clinic. Staff there wondered whether his loss of consciousness had been an initial episode of epilepsy. The GP arranged for Mr B to have an ECG (a recording of the electrical activity of his heart) and then referred him to the Trust's cardiologists.

Early the next month, Mr B saw a cardiologist who arranged a number of diagnostic tests. The test results were normal, but the cardiologist was still concerned, so they arranged for a small cardiac monitor to be implanted beneath Mr B's skin to monitor his heart rhythm.

Later that month, Mr B saw a neurologist. The neurologist was not certain of the cause of Mr B's previous loss of consciousness and arranged an MRI scan of his brain and an EEG to record the electrical activity of his brain. These could have helped confirm the diagnosis of epilepsy. However, the MRI brain scan was not done until about two months later.

Some days after the scan, in the early hours of one morning, Mr B died. This was before doctors had been able to diagnose why he lost consciousness four months before.

An inquest was held and the cause of his death was recorded as '*sudden death due to cardiac arrest or epilepsy*'.

Mr B's sister, Ms A, was unhappy with the care her late brother received from the Trust's cardiologist and neurologist. She believed that failings by the cardiologist and the neurologist resulted in her brother's death.

What we found

We partly upheld this complaint. There were no failings in the care the cardiologist gave Mr B. The cardiologist had arranged the right investigations for Mr B, in line with the relevant guidelines.

Although the neurologist had arranged the right neurological investigations for Mr B, it had taken longer for the neurologist to see Mr B, and for Mr B to have his MRI brain scan, than recommended by the National Institute for Health and Care Excellence (NICE).

However, we did not find that having the results of the neurological investigations sooner would have changed the outcome for Mr B. Mr B could have died as a result of an epileptic seizure, but NICE guidance recommends that anti-epileptic drugs are only started after a diagnosis of epilepsy has been confirmed and after a second epileptic seizure. Mr B's possible second epileptic seizure might have been the cause of his sudden and unexpected death.

The Trust's handling of Ms A's complaint was poor because of the time it took to investigate and respond, and because it answered one of her key questions without checking the facts. We recognised that this would have added to the distress Ms A and other members of Mr B's family suffered following his death.

Putting it right

The Trust acknowledged its poor service in handling Ms A's complaint, apologised for the added distress this caused her, and paid her £150.

It was important that the Trust learned lessons from the failings we found in Mr B's neurology care and in handling Ms A's complaint. The Trust wrote to Ms A to explain what it had done to learn lessons from this, and to make sure that the same things do not happen again.

Organisation(s) we investigated

Royal Berkshire NHS Foundation Trust

Location

Reading

Region

South East

Summary 1157/November 2015

Man considered mentally ill when he was not

Trust wrongly referred Mr D to mental health services and failed to assess him adequately.

What happened

Mrs D was concerned about her son's behaviour. She knew members of staff at the Trust professionally and asked them to visit Mr D at home. He asked them to leave, but then agreed to speak with them. The members of staff he saw referred him to another team within the Trust and then to its Early Intervention Psychosis Service.

Mr D went to a number of appointments and then stopped going. The Trust continued to try to meet with him but he told the Trust he stopped attending appointments because he felt things were going round and round. He then came back into contact with Trust staff after his mother reported him missing to the police as he had left the family home.

The Trust offered Mr D further appointments and talking therapy or medication which he did not take up. The Trust discharged him from its services shortly afterwards when it decided that he did not need any more help from mental health services.

Mr D complained that the Trust should not have accepted a referral from his mother, (which the Trust had already acknowledged it should not have done), and said that he felt pressurised to attend appointments. He said that as a result of the Trust's actions he had been labelled as mentally ill when this was not the case. He also said his career had been damaged.

What we found

Mr D was not given enough information to fully understand or make informed decisions about his treatment, and the Trust's assessments were not in line with established good practice.

Mr D felt pressurised to attend appointments because of the circumstances of his referral. We understood Mr D's concerns that he had been labelled as mentally ill despite not suffering from any illness or condition.

Putting it right

The Trust apologised to Mr D and made changes to its policies and procedures to make sure the same thing did not happen again.

Organisation(s) we investigated

Tees, Esk and Wear Valleys NHS Foundation Trust

Location

Northumberland

Region

North East

Summary 1158/November 2015

Trust's poor pressure ulcer care, blood flow assessment and record keeping

Mr Y's daughters will never know if better care might have improved their father's quality of life, but poor care did not hasten his death.

What happened

Mr Y was in his eighties, had advanced Parkinson's disease, high blood pressure and was taking a range of medicines. He was admitted to hospital in early 2013 with confusion and a pressure ulcer on his right heel. He developed two other pressure ulcers on his foot while in hospital. Mr Y was discharged and referred to district nurses for pressure ulcer management.

Mr Y was admitted to hospital again in spring for confusion, and then again in summer for facial swelling and concerns about his deteriorating and severe pressure ulcers. Doctors diagnosed him with poor blood flow (circulation) in his legs.

Two months later Mr Y went back to hospital with gangrene. Doctors discharged him with a view to providing him with palliative care, but he died at home a month later.

Mr Y's daughters, Mrs T and Ms F, complained that the Trust did not give their father appropriate care for his pressure ulcers and did not diagnose and treat his poor blood flow. They also said the Trust did not keep accurate and complete clinical records. They believed these failings led to their father developing more pressure ulcers and gangrene, which affected his quality of life and was very distressing for family members to see. They said that this hastened their father's death.

What we found

We partly upheld this complaint. There were numerous failings in Mr Y's pressure ulcer care including wound assessment and management, and record-keeping. Staff did not assess Mr Y's blood flow to his legs as they should have done, and did not carry out investigations when they diagnosed poor blood flow.

We did not find that the failings led to Mr Y developing new pressure ulcers, or that they led to his existing ulcers getting worse. We therefore did not find that his death was hastened by the failings.

However, there were missed opportunities to take action to reduce the risk of Mr Y developing pressure ulcers in the first place, but this also did not cause any new ulcers.

Mr Y's daughters would never know whether their father could have received treatment for his blood flow problems, which may have improved his quality of life. They also suffered frustration because of the Trust's poor record-keeping.

Putting it right

The Trust acknowledged the failings we found, apologised to Mrs T and Ms F for the injustice caused, and paid them £700. It prepared an action plan to show what it would do to improve pressure area care and blood flow assessment.

Organisation(s) we investigated

East and North Hertfordshire NHS Trust

Location

Hertfordshire

Region

East

Summary 1159/November 2015

Serious failings meant older man was not given the best chance of survival

Trust failed to take action after significant deterioration in Mr Q's condition, but we could not say that Mr Q's death was avoidable.

What happened

Mr B, in his late seventies, was admitted to hospital after he collapsed and complained of dizziness and back pain. He had a number of pre-existing conditions, including coronary heart disease and chronic kidney disease. Doctors thought his back pain was musculoskeletal or neurological and arranged for him to have an MRI scan to investigate this.

After a week in hospital, doctors told Mr Q's family that he could go home, but the family were concerned about his condition and his severe pain. Mr Q stayed in the hospital until the MRI scan, 12 days after his admission. After he had the scan, he was violently sick, and vomited black fluid three times. The following morning he complained of chest pain and a nurse carried out an ECG (a recording of the electrical activity of his heart). Mr Q's condition continued to deteriorate over the next two days. Mr Q collapsed after a further episode of vomiting and died.

A post-mortem showed that Mr Q had died from aspiration pneumonia (caused by inhaling vomit), a hiatus hernia (the stomach squeezes through an opening in the diaphragm), and that a kidney infection had contributed to his death.

Mr Q's family complained to us about the care he received.

What we found

Doctors had decided not to resuscitate Mr Q in the event of a heart attack, but this was not discussed with his family. The Trust had already acknowledged this and taken action to make sure that in future such decisions were discussed with patients' relatives.

When Mr Q vomited after the MRI scan, nursing staff did not tell medical staff, and no action was taken to monitor or investigate this. The ECG taken by the nurse was abnormal, but the nurse did not tell medical staff. Nursing staff recorded deterioration in Mr Q's condition overnight on the two nights before his death, but did not refer this to a doctor. Nursing and medical staff did not listen to the family's concerns that Mr Q was not eating and drinking, and failed to adequately monitor how much he ate and drank.

Despite staff knowing that Mr Q had chronic kidney disease, blood tests that could have shown a deterioration in his kidney function or inflammation or infection, were not done.

As some of the crucial information was missing, such as the ECG and blood test results from the day before he died, we could not say that Mr Q's death could have been avoided. However, there were serious failings in care which meant Mr Q was not given the best chance of recovery. Mr Q's family experienced distress that their concerns were ignored, and at witnessing Mr Q's deterioration and the circumstances in which he died.

There were failings in the way the Trust dealt with the family's complaint, delays in responding, and a failure to acknowledge serious failings.

Putting it right

The Trust wrote to Mr Q's son to acknowledge and apologise for its failings. It paid him over £1,200 in recognition of the distress caused to Mr Q's family. The Trust also developed an action plan to avoid a repeat of the failings we found.

Organisation(s) we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Location

Essex

Region

East

Summary 1160/November 2015

Trust failed to communicate appropriately with family of terminally ill child

A mother felt the Trust failed to acknowledge her anguish as she witnessed her young son's pain and distress in the final days of his life.

What happened

Mrs D's son, J, had previously been treated for leukaemia. Two years later he became ill again and was told his leukaemia had relapsed. He started treatment under a national clinical trial (ALLR3, in which children with leukaemia were treated with chemotherapy using different drugs), and this included a bone marrow transplant. During this time he contracted graft versus host disease. This is where the donor's immune system attacks the recipient's body tissues. Doctors treated this with steroids.

Five days later doctors suspected J had developed an infection and discontinued the steroid treatment. He continued to deteriorate and doctors told Mrs D that he was unlikely to survive. He died three days later in hospital.

Mrs D complained about J's care and treatment when he had a relapse of leukaemia. Her concerns included the lack of information the Trust gave her about the clinical trial, J's medication regime when he developed an infection, insensitive communication when clinical staff told her that her son was dying, delays in starting palliative care, and failure to provide suitable equipment to allow J to receive oxygen therapy when he used the commode.

What we found

We partly upheld this complaint. There were no failings in the clinical treatment J received for his leukaemia or infections.

However, there were failings in the way Mrs D was told J was dying. This had been partly acknowledged by the Trust, but we did not consider it had taken appropriate action to learn from this and improve its communication.

Also, when J received oxygen therapy, he was unable to keep his mask on when he needed to use the commode as the tube was not long enough. As he had severe diarrhoea because of the infections, this meant he had to take the mask off, which caused him considerable breathing distress.

The Trust had already acknowledged that it should have referred J for palliative care earlier, but it had not offered to put things right for the distress Mrs D experienced from witnessing her son's pain and distress in the final days of his life.

Putting it right

The Trust acknowledged its failings, apologised to Mrs D for the distress she was caused and paid her £750. The Trust created an action plan to address the failings we found to make sure the same mistakes were not repeated in the future.

Organisation(s) we investigated

The Royal Marsden NHS Foundation Trust

Location

Greater London

Region

London

Summary 1161/November 2015

Trust did not act on positive cancer test results

Mrs L's test results confirmed that she had advanced cancer. However, Trust staff did not act on this for nine months and so denied her the opportunity for treatment and a better prognosis.

What happened

In spring 2013 Mrs L suffered from postmenopausal bleeding. She had some tests which confirmed she had '*at least*' grade 2 uterine cancer, which meant that the cancer had spread to the cervix. The next month she had surgery at the Trust for a hysterectomy. Test results showed that she had grade 3 uterine cancer, which meant the cancer had spread beyond her uterus. However, staff did not review or act on the results. Mrs L's GP referred her back to the Trust at the beginning of 2014 and it was only then that staff looked at her results.

A month later, Mrs L had a CT scan, which showed her cancer had spread widely throughout her body. By this stage the cancer was terminal, and she could only be offered supportive care by the Macmillan team and the palliative care team. Mrs L then had a stroke and died a month later.

Mrs L's husband, Mr L, complained that his late wife was not given any cancer treatment or follow-up care following her hysterectomy in late spring 2013.

Mr L said that he and his wife were shocked when she was given the diagnosis of terminal cancer. He also said that the lack of care led to his wife's death, and the family had been left grieving and stressed by this.

What we found

Mrs L was discharged following her hysterectomy without any follow-up appointment being arranged. This was not in line with established good practice. She should have been seen by doctors at the Trust for a post-operative assessment within two to three weeks but this did not happen.

Mrs L's test results from the sample taken from her hysterectomy revealed she had advanced cancer. These results should have been brought to the attention of the multidisciplinary team (MDT) that was responsible for managing a patient's care and treatment, so that the team could discuss appropriate treatment options with her. This did not happen.

The MDT should have also had a system in place to make sure that it directly followed up on Mrs L's results after her surgery, reviewing and acting on them as required. The Trust failed to carry out any of this post-operative care, and therefore failed to provide Mrs L with appropriate care in line with established good practice and the relevant guidance.

We could not say that Mrs L's eventual death could have been avoided had she received better care. However, it is more likely than not that her prognosis would have been better.

Putting it right

The Trust wrote to Mr L to acknowledge the failings we identified and apologised for the impact these failings had on him. It also paid him £3,000. The Trust prepared an action plan to show it had taken steps to prevent the same failings happening again.

Organisation(s) we investigated

Gateshead Health NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 1162/November 2015

NHS Trust prescribed drugs that could have led to kidney damage

Ms A never knew whether prescribing two drugs together caused the damage to her father's kidney, and his death certificate did not reflect how he died.

What happened

Ms A's father, Mr A, was in his seventies. He went to hospital because he had prostate cancer that had spread extensively to his bones. He was already taking the drug Methotrexate for rheumatoid arthritis, but doctors should have stopped this when they diagnosed him with an infection.

In addition, Mr A was prescribed two other drugs, which Ms A believed should not have been prescribed together. She said this caused him to suffer from rhabdomyolysis (acute and rapid breakdown of muscle tissue) and acute kidney damage.

Ms A complained that when her father developed symptoms of rhabdomyolysis, doctors wrongly diagnosed and treated them. She also felt her father's acute kidney damage was not managed well enough and if it had been, he would have lived longer and his final weeks been more comfortable and less painful.

Mr A died in hospital shortly after the diagnosis of rhabdomyolysis and Ms A said the hospital's reason, in its complaint response, for her father's death differed from that in his death certificate.

What we found

We partly upheld this complaint. The Trust had already recognised that doctors should have stopped Methotrexate when Mr A was first admitted to hospital, and had taken reasonable steps to prevent the same thing happening in the future. There was no evidence that this had affected Mr A's further treatment.

Giving Mr A the two drugs together could have contributed to him developing rhabdomyolysis, which in turn could have led to acute kidney damage. However, we could not say with certainty that Mr A would not have developed rhabdomyolysis or acute kidney damage if these drugs had not been prescribed together. There was no evidence that Mr A's death had been hastened, or that the pain and discomfort he suffered in the final weeks of his life was because of the Trust's failings.

However, Ms A suffered uncertainty about what happened to her father because she had no way of knowing whether prescribing the two drugs together did cause rhabdomyolysis and potentially acute kidney damage, and because the death certificate did not reflect his acute deterioration.

Putting it right

The Trust apologised to Ms A for the uncertainty it caused her and explained the actions it had taken to learn from these events to make sure that the same thing did not happen again. We did not ask the Trust to recompense Ms A financially as she said she did not want that.

Organisation(s) we investigated

Royal Free London NHS Foundation Trust

Location

Greater London

Region

London

Summary 1163/November 2015

Trust wrongly refused to look at complaint on grounds that events happened too long ago

Mr C complained to the Trust in 2014 about care and treatment he received in 2009 and 2011. The Trust refused to look at his complaint, saying that he was too late because the events he complained about happened over 12 months before.

What happened

Mr C went to hospital in summer 2009 because he injured his ankle. The orthopaedic team diagnosed him with osteoarthritis and referred him to physiotherapy. After a few months' treatment he was discharged in early 2010.

His ankle continued to be painful and a year later Mr C's GP referred him again to the orthopaedic team. Mr C was dissatisfied with his care and treatment at the Trust and eventually his GP referred him to another hospital in 2012 for a second opinion. Doctors there diagnosed Mr C with a dislocated ankle and treated him until 2014.

Mr C said that as a result of the missed diagnosis, he experienced continuing pain and mobility problems in his foot, leg and hip, and this affected his ability to work.

Mr C complained to the Trust in summer 2014 about his orthopaedic care and treatment in 2009 and 2011.

The Trust told him that it could not deal with his complaint under the NHS complaints procedure as the problem happened more than 12 months before. But it did give him an explanation of the care and treatment he received in 2011. Mr C brought his complaint to us because he was unhappy with the Trust's decision not to look into his complaint.

What we found

We partly upheld this complaint. There was no evidence that Mr C had been misdiagnosed in 2009 or 2011, or that doctors at the Trust had missed the dislocation. We did not find any failings in the clinical care and treatment Mr B received.

The NHS complaints procedure says that complaints should be made within 12 months of the events complained about, but this time limit should not apply if the individual has good reasons for not making the complaint in that time, and that it is still possible to investigate what happened. Although more than 12 months had passed, Mr C had sought ongoing treatment for the problem and therefore it was a continuing issue.

If an organisation is able to investigate and answer questions about an event in the past, we would expect them to do so. We were able to investigate and give explanations about Mr C's care and treatment in 2009 and 2011, and therefore the Trust should have put the time limit aside and considered Mr C's complaint properly.

Putting it right

The Trust acknowledged that it should have responded better to Mr C's concerns under the NHS complaints procedure and apologised for this. It paid Mr C £150 in recognition of the frustration it caused him. It also made changes to its procedures to improve the way it handled complaints in the future.

Organisation(s) we investigated

Basildon and Thurrock University Hospitals NHS Foundation Trust

Location

Essex

Region

East

Summary 1164/November 2015

Delay in diagnostic tests left patient in pain

Mrs G was left with severe leg pain because of delays in ordering scans to diagnose and treat the pain.

What happened

Mrs G had previously had a graft to treat blocked leg arteries but she was still in pain. The Trust organised two separate Doppler scans (sound waves to measure blood as it flows through a blood vessel) to exclude a diagnosis of deep vein thrombosis.

It then took over two months before doctors ordered the next scans: a venogram (an X-ray to show how blood flows through the veins) and a fistulogram (an X-ray of abnormal blood vessels). Staff said this was due to the imaging department's error putting the information into the computer. Mrs G was left in pain during this time and could not sleep. Once the venogram was done, doctors found a stenosis (an abnormal narrowing in a blood vessel) and treated this. As soon as they did this, Mrs G's pain was relieved.

Mrs G's son, Mr H, complained to us. He said his mother was in real pain and discomfort while waiting for the correct scan. He said he and his family were unable to sleep as they were able to hear his mother screaming and shouting in pain.

What we found

The Trust unnecessarily delayed treating Mrs G for over two months and the delays were related to the clinicians ordering the tests, rather than the imaging department's computer error. There was duplication of the Doppler scans, and delay caused by clinicians not putting the request for a venogram correctly into the computer, which meant the imaging department was not aware of it.

Mrs G was left in pain and discomfort, and this also affected the rest of his family. Mrs G's pain could have been alleviated sooner, and therefore her and her family's distress could have been avoided.

Putting it right

The Trust acknowledged the delay in Mrs G's treatment, apologised for the pain she suffered during that time, and paid her £500 in recognition of this.

Organisation(s) we investigated

Barts Health NHS Trust

Location

Greater London

Region

London

Summary 1165/November 2015

Trust failed to offer cancer patient chemotherapy

Missed opportunity for a better quality of life and prognosis for Mrs F considerably distressed her daughter.

What happened

In spring 2014 Mrs F, who was in her late sixties, was diagnosed with small cell lung cancer. She was advised by the Trust that her diagnosis was terminal and she had just weeks or months to live. The Trust did not offer her any further treatment, such as chemotherapy, and said it could only offer her supportive care.

Mrs F's daughter, Mrs M, was unhappy with the lack of further treatment, and so spoke to her local clinical commissioning group (CCG). Following this, the CCG transferred Mrs F to another NHS trust, 11 weeks after her diagnosis. The second trust treated Mrs F with chemotherapy, but she eventually died in summer 2014, four months after her initial diagnosis.

Mrs M complained that the first Trust did not offer her late mother chemotherapy. She believed that, had it given her chemotherapy immediately after her initial diagnosis, the cancer may not have spread, and her mother's quality of life and prognosis could have been improved.

What we found

The first Trust should have offered Mrs F chemotherapy, and by failing to do so it did not act in line with the applicable guidance.

We could not say to what extent Mrs F's quality of life and prognosis could have been improved if the first Trust had offered and given her chemotherapy as soon as she was diagnosed with cancer. However, we could understand how this missed opportunity for a better quality of life and prognosis for Mrs F was, and will likely remain, a considerable source of distress for Mrs M.

Putting it right

The first Trust had already taken appropriate steps to improve its service in the light of this complaint. However, in order to give Mrs M further reassurance, the Trust showed us and Mrs M that improvements had been put in place. The Trust also paid Mrs M £1,500.

Organisation(s) we investigated

Luton and Dunstable Hospital NHS Foundation Trust

Location

Luton

Region

East

Summary 1166/November 2015

Patient's sight may have been saved

Trust failed to provide a patient with recommended steroid treatment.

What happened

Mr N was diagnosed with polymyalgia rheumatica (muscle pain and stiffness) in autumn 2012. He was treated with Prednisolone (a type of steroid). In 2013 he had further treatment with Prednisolone and the Trust suspected that he had giant cell arteritis (GCA, inflammation of blood vessels in the head and neck).

He went to his GP in spring 2014 with headaches and two short episodes of double vision. His GP urgently referred Mr N to the Trust's eye clinic and recommended he start taking Prednisolone again at a dose of 15mg. He saw an ophthalmologist at the Trust who increased the dose of Prednisolone to 40mg per day '*in view of the possibility of giant cell arteritis*'.

Shortly after this, he visited A&E two days running as he was concerned that his symptoms were worsening. Doctors increased the dosage of Prednisolone to 60mg then 80mg. Mr N woke the next day to find that he had lost the sight in his right eye.

Mr N believed the 40mg dose of steroids the ophthalmologist at the Trust gave him in spring 2014, was too low.

What we found

Guidelines for the management of GCA are clear; when a patient has evolving visual loss, as Mr N had, treatment should consist of '*intravenous methylprednisolone 500mg to 1g daily for three days*'. The Trust did not provide that recommended treatment.

We could not say definitively that the recommended treatment would have saved the vision in Mr N's right eye. However, there would have been a better chance of him not losing his sight. As a result of the Trust's failing, Mr N will never know if the sight in his right eye could have been saved.

Putting it right

The Trust apologised to Mr N for its failings, and paid him £1,000 in recognition of the fact that he will never know if he could have kept the sight in his eye if it had provided the appropriate treatment.

The Trust prepared an action plan to show what it had done to make sure that it had learned lessons from its failings, and to prevent the same thing happening again.

Organisation(s) we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 1167/November 2015

Missed diagnosis led to delay in corrective treatment

Mr K suffered a recognised complication after his operation, but the surgeon failed to diagnose it in his follow-up appointment, which led to a delay in further treatment.

What happened

Mr K had a hip replacement at an NHS treatment centre. He was warned before the operation that there was a slight risk that this could mean a change in the length of his leg (leg length discrepancy, LLD). He signed the consent form and the operation went ahead. Unfortunately he was one of the 1% of patients having this operation to suffer from LLD, which meant that his right leg was shorter than the left, and he would have to have more treatment to correct it. But the surgeon did not diagnose this in the follow-up appointment with Mr K.

Mr K believed there might have been failings in his treatment, and that LLD could have been avoided. Mr K asked for a second opinion and eventually had the corrective treatment done at another hospital.

What we found

We upheld this complaint. There was no evidence to suggest the LLD was as a result of any failings in the treatment Mr K received.

However, the surgeon was wrong not to physically examine Mr K at his six week follow-up appointment, and this failing led to a delay in diagnosis and further treatment. The delay did not have any impact on Mr K's long-term health or recovery, and the further treatment would have been the same if the problem had been found sooner.

However, we acknowledged that it was distressing for Mr K to have to wait longer than he should have done for diagnosis and further treatment. When Mr K complained to the Treatment Centre it should have accepted that fact much sooner and tried to make amends.

Putting it right

The Treatment Centre apologised for the failings we found and paid Mr K £750.

Organisation(s) we investigated

Care UK - Shepton Mallet NHS Treatment Centre

Location

Somerset

Region

South East

Summary 1168/November 2015

GP did not give patient oxygen or call for an ambulance

Trust's out-of-hours GP failed to give appropriate care and treatment to a dying man at home, but this did not contribute to his death.

What happened

Mr J had lung disease, bowel cancer, liver metastases and was receiving palliative care. In spring 2014, his wife, Mrs J, called 111 as he was unwell. The Trust's out-of-hours GP visited Mr J at home. Mr J had blue fingers, reduced oxygen saturation levels, a raised heart rate and was breathing quickly.

The GP felt that Mr J needed to be admitted to hospital and he went out to his car to call the hospital and arrange this. He also called for a community nurse to come to the house. During this time, Mr J collapsed on to the floor. Mrs J had to run out to the car to get the GP who then returned to the house and tried to resuscitate Mr J. An ambulance was called but Mr J passed away soon after the paramedics arrived.

Mrs J complained to the Trust about the care and treatment the GP gave to her husband. She also complained that the community nurse was unprofessional and talked and laughed with the paramedic while Mr J was dying. The Trust responded to Mrs J's complaint, but she was dissatisfied with its responses so she complained to us.

Mrs J believed her husband's death could have been avoided if the GP had given him appropriate care and treatment.

What we found

We partly upheld this complaint. The Trust had made robust attempts to investigate Mrs J's complaint about the community nurse, and interviewed her and the ambulance crew. However, based on the available evidence, we were unable to reconcile their's and Mrs J's account of what happened.

The GP failed to give Mr J oxygen despite his low oxygen saturation levels, and this fell significantly short of established good practice. The GP also acted inappropriately by not immediately calling for an ambulance for Mr J as he should have done, rather than speaking to the hospital about admitting him.

The GP should have stayed with Mr J while he was on the phone, rather than going to his car, as by doing so he was unable to appropriately monitor him.

Since Mrs J's complaint to the Trust, the GP had showed that he had reflected on and learned from Mrs J's complaint so that the same mistakes would not happen again.

It was unlikely that the outcome for Mr J would have been different had these failings not occurred. However, the failings in Mr J's care had resulted in ongoing distress for Mrs J as she witnessed the poor care her husband received. She was also denied the reassurance that everything that could have been done for her husband, had been done.

Putting it right

The Trust wrote to Mrs J to acknowledge the failings we found and apologised for the impact of these failings. It also explained what it had done to make sure the GP had learned from the complaint, so that he calls for an ambulance quickly for a patient such as Mr J who needs to go to hospital urgently.

Organisation(s) we investigated

County Durham and Darlington NHS Foundation Trust

Location

Darlington

Region

North East

Summary 1169/November 2015

Palliative care nurses did not use correct pain relief

Doctor gave nurses instructions to treat Mrs C with continuous pain relief medicine under her skin, but the nurses treated her differently.

What happened

Mrs C was in hospital and in continuous pain. Her doctor instructed the palliative care nurses to treat her with continuous pain relief through a syringe driver (which delivers pain relief medicine under the skin). The nurses disagreed with the doctor's instruction and decided to administer pain relief in a different way. They did not use the syringe driver until the next day.

Mrs C's grandson, Mr B, complained to the Trust that the nurses disregarded the doctor's instructions and that some nurses were not aware of the prescription needed for the syringe driver.

Mr B said that this meant his grandmother suffered severe pain before she passed away, which was distressing for her and all the family.

What we found

We partly upheld this complaint. The Trust did not always provide reasonable care and treatment for Mrs C. She received less pain relief than she would have done through the syringe driver. Palliative care nurses did not start the syringe driver as they disagreed with the doctor's instruction and this fell below the applicable standards.

Nursing staff knew about the prescription for the syringe driver, but decided not to start it.

Putting it right

The Trust apologised to Mr B and told us what it had done to make sure the same thing did not happen again.

Organisation(s) we investigated

East and North Hertfordshire NHS Trust

Location

Hertfordshire

Region

East

Summary 1170/November 2015

The Trust failed to appropriately monitor patient

The Trust did not appropriately monitor an older lady on a rehabilitation unit, but this did not lead to her death.

What happened

Mrs H was in her nineties and taken to A&E after falling at home. Doctors transferred her from A&E to the medical assessment unit, and then to the medical short stay unit the following day. Staff there decided that Mrs H was medically fit for discharge from hospital and recommended she had nursing and rehabilitation care at an intermediate care and rehabilitation unit. Mrs H stayed on the rehabilitation unit for about a month before she died.

Mrs H's daughter, Mrs M, said there was poor nutrition, record keeping and communication in A&E; there were inappropriate transfer times between the different wards; Mrs H was not monitored correctly; and there was an issue with blood tests on the rehabilitation unit. Mrs M said if Mrs H had stayed on a ward rather than the rehabilitation unit she would not have deteriorated and died.

What we found

We partly upheld this complaint. There were failings in some aspects of the care the Trust provided, including inappropriate transfer times, an issue with blood tests and the level of monitoring Mrs H received on the rehabilitation unit.

We did not find failings in relation to nutrition, record keeping or communication in A&E.

Putting it right

The Trust apologised to Mrs M for its failings and the impact these had on Mrs H.

The Trust produced an action plan to explain how it would improve patient monitoring on the rehabilitation unit.

Organisation(s) we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 1171/November 2015

Inadequate support for daughter while health budget decided

A clinical commissioning group (CCG) failed to put in place a funding plan for a young girl in reasonable time, and did not provide adequate support for her family in the meantime.

What happened

G had complex learning difficulties and health problems and required 24-hour care. Her parents found that she was eligible for NHS continuing healthcare funding in the summer of 2013 and they filled in a Personal Health Budget (PHB) referral form detailing the carer support she needed. Her mother, Mrs R, told the CCG that she had filled in the form as they may need help in the future, but the family did not require any help at that time.

Four months later Mrs R told the CCG that she wanted the PHB put in place. About two months later, in early 2014, the CCG started the process of setting up the budget for care. Four months later, in late spring 2014, G died and the PHB had still not been set up. This was nearly seven months after Mrs R had asked the CCG to implement the PHB. Throughout this time G's family provided all her care.

Mrs R complained to the CCG and it paid her around £5,000 to cover G's care costs based on what she would have received if the PHB had been correctly set up. Mrs R was unhappy with this amount as she felt this did not take into account how much care the family had provided, so she came to us.

Mrs R said the time that they had left with G was made a lot more stressful because they did not get any support.

What we found

There were significant delays in setting up the PHB but we were satisfied that the CCG had already taken sufficient action to address this.

The CCG failed to provide appropriate support to the family while they were waiting for the PHB to be implemented. This placed additional stress on the family which had not been put right by the payment the CCG had already made.

Putting it right

The CCG paid Mrs R £2,000 for the stress caused to the family by its delay in implementing the PHB, and the lack of support it provided to them during this time.

The CCG drew up an action plan to address the failures we found to make sure the same thing did not happen again.

Organisation(s) we investigated

South Manchester Clinical Commissioning Group (CCG)

Location

Greater Manchester

Region

North West

Summary 1172/November 2015

Trust caused unacceptable delays in cancer care

When Mrs M developed cancer, there were unnecessary delays in doing tests and getting results back, but this did not affect her prognosis.

What happened

Mrs M was in her early seventies when her GP referred her to the Trust because of abdominal pain and a change in bowel habits. She went to her outpatients' appointment in spring 2013 and the clinician referred her for a CT colonography (CTC), a scan that shows pictures of the colon and rectum. The referral got lost in the system so the CTC scan didn't happen for a month. Following the CTC, doctors referred Mrs M for a colonoscopy (a test to assess the colon) and a biopsy, as the Trust suspected Mrs M had colon cancer.

Again there were delays because the referral for the colonoscopy could not be found in the system, and it took place about six weeks later. This showed no problems with Mrs M's colon but doctors decided her problems might be gynaecological. About two weeks later she was diagnosed with aggressive ovarian cancer and Mrs M and her husband felt the consultant broke the bad news to them in too casual a manner.

Mrs M had chemotherapy but died ten months later. Mr M complained about the delays in diagnosis and treatment; he believed his wife could have lived longer if she had had earlier treatment.

What we found

We partly upheld this complaint. There were unnecessary delays in carrying out Mrs M's tests and getting the results back. These meant Mrs M could have started her chemotherapy about six weeks earlier. However, her cancer was already so advanced when it was found that it was unlikely she would have survived longer even if she had had earlier treatment.

All of the above caused unnecessary anxiety and distress to Mr and Mrs M.

Putting it right

The Trust apologised to Mr M and paid him £250. It also produced an action plan to make sure the failings we found did not happen again.

As a result of this complaint the Trust had already extended the time of the appointment slots when a consultant has to break bad news.

Organisation(s) we investigated

Brighton and Sussex University Hospitals NHS Trust

Location

Brighton & Hove

Region

South East

Summary 1173/December 2015

Trust did not manage patient's pain

Trust did not to adequately monitor and manage Mr F's pain while he was in hospital which caused his wife distress as she had to watch him suffer.

What happened

Mr F was diagnosed with cancer in autumn 2012. Doctors began treating him as an outpatient with chemotherapy, and changed to radiotherapy when his disease got worse. Throughout his treatment Mr F suffered extreme anxiety about it and was in pain.

Doctors admitted Mr F to hospital in winter 2013 because he had raised blood sugar levels, nausea and abdominal pain. Initially doctors suspected Mr F had type 1 diabetes and Mrs F said they diagnosed this, which caused her husband further distress. Doctors later diagnosed Mr F with steroid induced diabetes. He also suffered from a bout of severe diarrhoea.

Mr F's condition deteriorated and his pain got worse. He and his wife felt his pain was not managed properly.

Three weeks later, Mr F's condition rapidly deteriorated further and he became extremely distressed because he was in pain and suffering from nausea. He suffered a cardiac arrest and Trust staff were unable to revive him. He died shortly afterwards.

Following her husband's death Mrs F complained to the Trust about his pain management and its communication with her and her husband. As part of the Trust's complaint response she received two different explanations for the cause of her husband's diarrhoea.

What we found

We partly upheld this complaint. The Trust failed to adequately monitor and manage Mr F's pain, which caused Mrs F distress as she had to watch her husband suffer. The Trust's explanations about the cause of Mr F's diarrhoea were inconsistent and not based on any evidence.

There were no failings in how the Trust assessed and investigated Mr F's cancer. While the doctors did not communicate effectively with Mr F about the type of diabetes he had, they did not misdiagnose him with Type 1 diabetes, because they only suspected this.

The standard of complaint handling did not fall so far short of applicable standards as to be poor service. Due to the lack of independent evidence, we were unable to say whether doctors acted unprofessionally in their communication with Mrs F.

Putting it right

The Trust apologised to Mrs F and paid her £1,000 for the distress it caused her in failing to manage her husband's pain. It produced an action plan to show what it had done to help prevent the same thing happening again.

Organisation(s) we investigated

Oxford University Hospitals NHS Trust

Location

Oxfordshire

Region

South East

Summary 1174/December 2015

Trust did not tell family that patient had fallen in hospital

Trust staff failed to monitor, record and communicate about Mrs A's care as it should have done.

What happened

Mrs A was admitted to the Trust in winter 2012 after she collapsed at home. Doctors investigated her condition and decided she was well enough to be discharged two weeks later. Staff delayed her discharge because she needed social work assessments and adaptations to her home.

Six weeks after Mrs A was admitted, she fell on the ward and hit her head. Doctors carried out an assessment and decided an immediate CT scan (shows images of the inside of the body) was not necessary. After this Mrs A began to deteriorate, although doctors found no link between the fall and her deterioration. Trust staff did not tell her family about the fall or initially about her deterioration. Three weeks after her fall, Mrs A died.

Mrs A's daughter, Mrs W, complained to us because she said her mother's rapid decline caused her and her family extreme distress and anxiety. She felt staff could have given her mother better care, and that their failure to do so led to her deterioration.

What we found

We partly upheld this case. The Trust failed to tell Mrs A's family about her fall and delayed telling them about her decline. It also did not carry out the appropriate neurological observations, which was not in line with the applicable standards. Nursing records were unclear, documentation about Mrs A's care and treatment was poor, and nurses failed to monitor the fluid going in and out of Mrs A's body. This caused Mrs W and her family unnecessary distress and Mrs W felt let down by the Trust.

However, there was no clinical impact on Mrs A as a result of the failings we found. While her neurological observations were not assessed adequately, her fall did not cause her decline but was a symptom of it, and while a CT scan suggested Mrs A had experienced a bleed into an area of her brain, the post-mortem found no evidence of a haemorrhage. Although nurses failed to record Mrs A's fluid intake and output, the records show clinical staff regularly offered her food and drink.

Putting it right

The Trust apologised to Mrs W for the failure in service we found, and paid her £500 for the distress this caused her. The Trust produced an action plan to show what it had done to help prevent the same thing happening again

Organisation(s) we investigated

Royal United Hospitals Bath NHS Foundation Trust

Location

Bath and North East Somerset

Region

South West

Summary 1175/December 2015

Midwives failed to manage an emergency during a water birth

Mrs B had a difficult birth and midwives did not call an ambulance soon enough. Her baby was under water for ten minutes, and he probably suffered respiratory distress because of this.

What happened

Mrs B chose to deliver her son in a birthing pool with the help of midwives. After the baby's head showed, a midwife found that one of his shoulders was stuck behind Mrs B's pubic bone (shoulder dystocia). It took a further ten minutes for the midwives to deliver the baby, who spent most of that time under water in the birthing pool. When the baby was born he was not breathing and the midwives had to resuscitate him.

Mrs B's friends were at the birth and took photographs of what happened. The midwives then transferred the baby to a specialist hospital for more intensive treatment, including ventilation. The baby was allowed home three weeks later, and ongoing tests showed that he did not have long term health problems.

Mrs B complained to the Trust about the standard of care she received during the birth. She said that her child suffered respiratory problems and had to be taken to hospital as an emergency. Mrs B said she also suffered distress because of this.

Mrs B came to us because she said the Trust did not investigate her complaint thoroughly. She said it did not resolve inconsistencies in her and her friends' accounts of events, or take note of the results of an independent midwifery report it commissioned.

What we found

The midwives should have called for an ambulance as soon as they noticed the shoulder dystocia and immediately helped Mrs B out of the pool. As a result, Mrs B's son was under water longer than he should have been, and it was likely that he suffered respiratory distress because of this.

When Mrs B was giving birth, the midwives did not carry out the McRoberts Manoeuvre (bending her legs tightly to her abdomen) in the correct position. She also received inadequate care after her son was born and the midwives failed to record the information they should have done during the birth.

Mrs B also suffered distress due to the poor treatment, and this was made worse by the Trust's poor handling of her complaint.

Putting it right

The Trust acknowledged its failings, apologised for the injustice Mrs B and her son suffered, and paid her £750. It produced an action plan to make sure the same things did not happen again and explained how it would monitor improvements.

Organisation(s) we investigated

Royal Free London NHS Foundation Trust

Location

Greater London

Region

London

Summary 1176/December 2015

Woman in her eighties spent nearly ten months in hospital after she was ready to be discharged

Clinical Commissioning Group (CCG) delayed getting involved with Mrs J's discharge, so her daughter got legal advice.

What happened

Mrs J lived at a nursing home but had to go to hospital because she had dehydration and bed sores. When she was ready to be discharged, the CCG responsible for paying for her care in hospital said that Mrs J was now eligible for continuing healthcare funding, so it would pay for her care in a nursing home.

Mrs J's daughter, Mrs V, wanted her mother to be cared for in Mrs V's home which was in a different area. This meant that any care Mrs J needed would have to be agreed and paid for by the CCG responsible for that area. Mrs V approached the second CCG and asked if it would work with her to put in place a package of care so that her mother could be discharged to Mrs V's home. The CCG said it could not do this because Mrs J was not permanently registered with a GP in its area. Mrs V then registered her mother with a GP in the area, but the CCG raised other objections and continued to refuse to get involved.

After several months and the involvement of Mrs V's solicitors, the second CCG agreed to take part in the process. Eventually both CCGs came to an agreement about the arrangement and funding of Mrs J's care, and she was discharged from hospital, several months later than she should have been.

Mrs V complained about the delays the second CCG had caused, and wanted to recover some of the legal fees she had incurred.

What we found

The second CCG should have been involved much earlier in Mrs J's discharge planning, in line with the relevant guidance. This caused injustice to Mrs V and Mrs J, and caused Mrs V to incur legal fees.

Putting it right

The CCG apologised to Mrs V because its actions had contributed to the delay in Mrs J's discharge. It paid Mrs V £5,000 towards her legal fees and explained what changes it had made so that the same thing did not happen again.

Organisation(s) we investigated

Lewisham Clinical Commissioning Group (CCG)

Location

Greater London

Region

London

Summary 1177/December 2015

No failure in the Trust's treatment of heart problems

Trust gave Mrs A treatment that was clinically appropriate for her heart condition.

What happened

Ms A had a persistently high heart rate. Different medications failed to control her symptoms, so she went to a private doctor who treated her with a sinus node ablation (where heat is used to remove areas of tissue that have caused abnormal heart rhythms). During the procedure doctors found other abnormal heart rhythms and treated them. Ms A continued to experience symptoms and went on to have two more sinus node ablations done privately.

Ms A then started to experience recurrent palpitations. She went to the Trust and doctors treated her with another ablation.

After the operation, she experienced a dangerously slow heart rate so doctors fitted her with a single chamber pacemaker (it has a single lead to the heart). She continued to have problems and had a further ablation. Doctors at the Trust also replaced her pacemaker with a dual chamber pacemaker (which has two leads to the heart).

She continued to have palpitations, so she went to another private doctor who gave her further treatment and replaced one of the leads of her pacemaker.

Ms A complained that the Trust had performed unnecessary ablation procedures because these did not resolve her heart problems and that doctors did not explain the reasons for this properly.

She also complained that a lead on her second pacemaker should have been changed earlier. She said she still has to have regular treatment to address problems she believes were caused by the unnecessary treatment.

What we found

We did not uphold this case. The ablations the Trust carried out were clinically appropriate attempts to resolve Ms A's heart problems. We were satisfied that the private treatment she had after she experienced palpitations did not arise out of any failings in care the Trust gave her. It was also reasonable for the Trust not to replace the lead on her second pacemaker.

While we could strictly only consider what had been documented in the Trust's notes (and not the private doctors' notes), Ms A discussed her condition with both the Trust and private doctors. Within this context Trust staff held reasonable discussions with her, and Ms A knew about the risks of the ablation procedure as she had signed the consent forms.

Overall we did not find the Trust's care and treatment of Ms A was a failure in service.

Organisation(s) we investigated

East Sussex Healthcare NHS Trust

Location

East Sussex

Region

South East

Summary 1178/December 2015

Delay in requesting CT scan led to avoidable death of patient

Trust did not carry out an urgent CT scan when Mr J's mother's condition deteriorated after she had been treated for kidney failure.

What happened

Mrs J was admitted to hospital with kidney failure, which was treated successfully. Three days after this she went into a coma and her Glasgow Coma Score (GCS), which records a patient's conscious state, fell from 15 to 11, and shortly afterwards fell further to 3. This meant her level of consciousness deteriorated rapidly until she became deeply unconscious.

Doctors placed Mrs J on a ventilator and sedated her. The next morning doctors requested a CT scan of her head. The CT scan showed an acute left subdural haematoma (a bleed on the surface of the brain). This was fatal and Mrs J died the next day.

Her son, Mr J, wanted to know if his mother's death was avoidable.

What we found

The fall in Mrs J's GCS score from 15 to 11 should have made doctors request an urgent CT scan. Failure to do this was contrary to established good practice and was a significant failing. If doctors had requested the CT scan immediately, Mrs J would have had surgery to relieve the pressure on her brain caused by the subdural haematoma. If this surgery had taken place, it is more likely than not that Mrs J would have survived and made a full recovery.

Mr J has to live with the fact that his mother's death was avoidable.

Putting it right

The Trust apologised to Mr J and paid him £10,000 for the failure in service and the injustice this caused him.

It produced an action plan to show what it had done to learn lessons from the failings we found, and what it had done or planned to do to avoid the same thing happening again.

Organisation(s) we investigated

Lewisham and Greenwich NHS Trust

Location

Greater London

Region

London

Summary 1179/December 2015

Young woman died because of incorrect hangover diagnosis

A&E doctor failed to take blood and urine tests so did not diagnose a potentially life-threatening complication of diabetes.

What happened

Miss M suffered from type 2 diabetes and Asperger's Syndrome and was taken to A&E with chest and abdominal pain. She had been drinking heavily the previous evening and had also vomited.

Staff gave Miss M intravenous fluids, pain relief and anti sickness medication. A doctor reviewed her, diagnosed her with a hangover and discharged her. She died at home the following day from severe diabetic ketoacidosis (a potentially life-threatening complication of diabetes caused by a lack of insulin in the body).

Mr & Mrs M complained to the Trust that despite being made aware of their daughter's diabetes, the A&E doctor did not take blood and urine samples. They said this was a missed opportunity to correctly diagnose Ms M, and therefore give her treatment that would have saved her life.

The Trust said that Miss M had been given a standard of care that was in line with its Adult Diabetic Ketoacidosis (DKA) pathway and the national guidelines. The Trust denied that Miss M had been labelled as '*just drunk*'.

Mr and Mrs M were unhappy with the Trust's response so they came to us. They wanted the Trust to acknowledge its failings, make improvements to its service and give them compensation to cover their daughter's funeral expenses.

What we found

The care and treatment the Trust gave Miss M fell so far below the applicable standards that it amounted to a failure in service. The Trust had not put this injustice right. Miss M's death would have been avoided if she had been appropriately assessed in A&E. Staff should have recognised that a combination of vomiting, alcohol ingestion and underlying diabetes could together have contributed to severe diabetic ketoacidosis, which could have been fatal. If Ms M had had the appropriate tests then doctors would have admitted her to hospital so she could have received life-saving treatment.

Putting it right

The Trust acknowledged its failings and apologised to Mr and Mrs M. It paid them nearly £7,000 for their daughter's funeral expenses and put in place a plan to avoid a recurrence of similar failings in the future.

Organisation(s) we investigated

North Middlesex University Hospital NHS Trust

Location

Greater London

Region

London

Summary 1180/December 2015

Trust failed to diagnose lung cancer

Medical staff failed to diagnose Mrs R's lung cancer, despite it showing on her chest X-ray.

What happened

Mrs R had a number of health conditions and went to hospital in autumn 2013 with a broken arm. A doctor suspected she also had a chest infection and ordered an X-ray of her chest. The X-ray showed she had lung cancer and this was recorded electronically. But the doctors treating Mrs R did not review the X-ray results and discharged her after five days.

Eight months later she went to hospital again with breathing difficulties. Doctors diagnosed her with pneumonia and an infection of an unknown source, and admitted her to the Acute Medical Unit. She died two days later.

Mrs R's son, Mr S, and his partner, Ms T, complained about the failure of Trust medical staff to diagnose Mrs R's lung cancer in autumn 2013, despite the report of her chest X-ray noting the cancer. They said that Mrs R would have lived longer and suffered less if it hadn't been for this failing. The family were distressed by her suffering.

What we found

We partly upheld this complaint. Trust staff did not comply with relevant National Institute for Care and Health Excellence guidance in caring for Mrs R. Not reviewing the X-ray was a serious failing. If doctors had diagnosed Mrs R's lung cancer at the time, it would not have extended her life due to her frailty and other health problems but it would have given her and her family the opportunity to come to terms with her terminal illness.

Putting it right

The Trust apologised for the distress caused, and paid Mr S and Ms T £1,750. It reminded its clinical staff of their responsibility to adhere to relevant national guidance when caring for patients.
It also put in place action plans to prevent the same thing happening again. These plans showed that clinicians ordering investigations for patients should make sure that they review the results and act on them, and that electronic radiology reports are automatically sent to the doctor. It also reminded its radiologists of the requirement to speak directly to the doctor when there is a serious concern about the results of an X-ray.

Organisation(s) we investigated

City Hospitals Sunderland NHS Foundation Trust

Location

Tyne and Wear

Region

North East

Summary 1181/December 2015

Trust failed to diagnose thyroid cancer

Trust didn't assess or diagnose patient properly and this led to her going to another hospital to find out she had cancer.

What happened

Mrs W went to her GP in early summer 2010 complaining of hoarse speech. The GP suspected cancer as one of the possible symptoms of thyroid cancer is a hoarse voice. He referred her to the Trust's Ear, Nose and Throat (ENT) service.

The ENT consultant saw Mrs W later that month and diagnosed vocal cord palsy (one or both vocal cords not moving). A CT scan did not show any cause for the vocal cord palsy, but there were calcified nodules (lumps) in her thyroid gland. She had speech therapy and was then discharged in early 2011.

Mrs W continued to have voice problems and her GP re-referred her to the ENT service two months later where she had more speech therapy. Towards the end of the year her vocal cord palsy had improved slightly and she had more speech therapy in early 2012.

In summer 2012 Mrs W collapsed in the street with breathing difficulties and went to A&E. She was discharged from hospital into the care of her GP with the possibility of being referred to the Trust's respiratory doctors. The GP ordered blood tests, found Mrs W had an over-active thyroid and referred her to a consultant endocrine surgeon at another trust (the second trust) who admitted her.

Tests there revealed she had thyroid cancer, which had spread to some of her muscles and lymph nodes. Mrs W had surgery and radiotherapy treatment at the second trust's hospital where they found the cancer had spread to her spine.

In early summer 2013, Mrs W went to the first trust's A&E department as she had been suffering with severe right shoulder and neck pain for six weeks and was coughing up blood. Tests revealed that the cancer had spread to more areas of Mrs W's spine. Her family asked that she be transferred back to the second trust. Before she went, staff at the first trust contacted specialist neurosurgeons at a third trust for advice, and they recommended that Mrs W be fitted with a neck brace to protect her spinal cord during the transfer. The first trust transferred Mrs W to the second trust a month later but staff failed to fit her with a neck brace for the transfer. Mrs W died a month later.

Her husband, Mr W, said that because of the first Trust's failings an opportunity was lost to save his wife's life. He said he suffered financially, as he had to give up work to care for her, and also emotionally from his loss.

What we found

We partly upheld this complaint. The (first) Trust's ENT staff had investigated Mrs W's symptoms appropriately. However, staff failed to assess her adequately when she went to A&E in summer 2012. Tests showed that she should have been further assessed before she was discharged. This meant there was a delay in treating Mrs W's breathing difficulties, and a further delay in treating her over-active thyroid and finding her thyroid cancer. However, while the delays in diagnosis and treatment caused Mrs W and her husband distress, they did not affect her prognosis.

When she went back to the Trust in early summer 2013 staff failed to give her a neck brace when they transferred her to the second trust for treatment. As a result, she suffered more pain than she need have done and this meant the risk of spinal cord damage increased.

The inadequate assessment in the A&E department in summer 2012 and the failure of Trust staff to provide her with a neck brace in early summer 2013 fell so far below established good practice that it amounted to a failure in service.

Putting it right

The Trust acknowledged its failure in service, apologised to Mr W for the distress this had caused him and paid him £500. It prepared an action plan to show what it had done to make sure that its staff had learned from the failings we found, and explained what it had done to avoid the same thing happening again.

Organisation(s) we investigated

Wrightington, Wigan and Leigh NHS Foundation Trust (the first trust)

Location

Warrington

Region

North West

Summary 1182/December 2015

Delay in diagnosing cancer for two months

Doctors could have diagnosed Mr H's cancer much earlier if Trust had done a scan when he was first admitted to hospital.

What happened

Mr H went to hospital in early summer 2014 with severe neck pain. He had an X-ray but doctors found no signs of a fracture. He was admitted, given analgesia and treated for a flare up of chronic obstructive pulmonary disease (a lung disease) and an irregular heartbeat. Doctors discharged him four days later as medically fit and planned no follow-up appointment. Mr H went to A&E the next day because the pain in his neck was still severe, and doctors prescribed pain killers.

A month later the pain had not got any better so Mr H went to his GP who referred him to the Trust's spinal clinic. Doctors there took another X-ray and noticed an abnormality, so they referred him for an urgent MRI scan. When the results came back doctors immediately sent him to A&E where he was diagnosed with a collapsed vertebrae and a tumour on his neck. It was later discovered that the cancer was mainly on his lungs but that it had spread to his bones. Mr H was admitted to hospital and stayed there until he passed away, two months after he first went to hospital with neck pain.

Mr H's wife, Mrs H, and his daughter, Mrs P, complained that the Trust failed to diagnose Mr H's neck tumour when he was first admitted in early summer, and discharged him without referring him to the spinal clinic. Mrs H and Mrs P said Mr H did not have access to a call buzzer on many occasions.

They complained staff did not help him to drink, move him around in bed, monitor his pain levels, or investigate his swollen and painful arm. They also said staff ordered Mr H a puréed diet when he was able to eat solid food, laid him flat for no clinical reason, and communicated poorly with the family.

The Trust identified some of these failings during its own investigation, but Mrs H and Mrs P were unhappy with its response, so they came to us.

Mrs H and Mrs P said that failures in care led to Mr H's death and that the whole family had been left '*traumatised*' by what happened.

What we found

We partly upheld this complaint. The Trust should have done an MRI scan when Mr H was first admitted to hospital. This would have allowed doctors to diagnose the cancer at a much earlier stage. Mr H should also have had access to a call buzzer at all times, staff should not have laid him flat two days before his death and they should have communicated better with Mr H's family about his diagnosis and prognosis.

Although we could not say that Mr H's death could have been avoided if he'd had better care, we could say that the quality of his life would have been greatly improved, and that Mr H and his family would have had a much longer period of time to come to terms with the prognosis.

Putting it right

The Trust acknowledged its failings, apologised to Mrs H and Mrs P for the impact these failings had on the family and paid them £2,000. It also drew up plans to make sure that the failings we found would not be repeated.

Organisation(s) we investigated

Lancashire Teaching Hospitals NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 1183/December 2015

Hospital lets down woman in premature labour

Ms G complained about the treatment she received when she went into early labour at 27 weeks pregnant.

What happened

Ms G went into early labour with mild contractions and was admitted to a Trust hospital that could care for very premature babies. Doctors at the Trust treated her with medication to postpone her labour and kept her in hospital for four days before discharging her. She was readmitted a few days later with bleeding and mild contractions and this time stayed in hospital for just over a week. During this time Ms G found it difficult to pass urine (urinary retention). She was discharged home again and she then went to another hospital as she had been unhappy with the care she had received from the Trust. Ms G gave birth to a healthy baby at 33 weeks at this hospital.

Ms G complained to the Trust about several aspects of her care, including communication and staff attitude, failure to monitor her for serious side effects of her medication, inappropriate discharge from hospital, delay in arranging a medical review; and poor management of her urinary retention.

Ms G said that as a result of this she had been affected both physically and psychologically, and had been left with an overactive bladder.

What we found

Ms G was discharged inappropriately twice when she was having mild contractions and therefore going into labour. Midwives failed to monitor Ms G's fluid balance so they didn't notice that she was retaining urine. If they had, they should have called a doctor. Doctors did not explain the risks and side effects of one of the drugs they gave Ms G. These issues caused Ms G to suffer unnecessary worry and distress.

Putting it right

The Trust apologised to Ms G and explained what actions it would take to prevent a recurrence.

Organisation(s) we investigated

Taunton and Somerset NHS Foundation Trust

Location

Somerset

Region

South West

Summary 1184/December 2015

Patient discharged before scan

Mr T was discharged from A&E with a fracture and had to have a hip replacement operation the next day.

What happened

Mr T fell in the street. He was taken to hospital by ambulance, was in significant pain and unable to stand. Staff in A&E took an X-ray and gave him some pain relief. After a few hours doctors felt there was no evidence of a fracture and staff helped him to the hospital exit in a wheelchair. Mr T fell when he tried to stand up and had to be readmitted to hospital. A few hours later another doctor arranged further scans and found that Mr T had fractured his hip. Mr T had a total hip replacement operation the next day.

Mr T said his experience had a traumatic effect on his mental health and wellbeing. He said he suffered severe pain at the time and has nightmares about what happened.

What we found

There were significant failings by staff in A&E. They failed to follow the relevant standards and established good practice. Staff did not give Mr T the pain relief he needed and made a decision to exclude the possibility of a fracture without having enough evidence to make that decision. We did not find that Mr T's treatment in A&E led to any further physical damage but he was clearly in pain for several hours. His pain was severe at times and there is evidence that he screamed when staff tried to move him. Mr T's second fall was also clearly distressing for him. We understood why the poor treatment he had at the hospital led to him experiencing continued distress.

Putting it right

The Trust acknowledged its failings, apologised for the impact they had on Mr T and paid him £500. It also showed that it had learned from our findings.

Organisation(s) we investigated

Central Manchester University Hospitals NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 1185/ December 2015

Trust did not tell family about mother's fall in hospital

Ms F complained that her mother, Mrs Z, was not provided with a reasonable level of care at the end of her life.

What happened

Mrs Z was taken to hospital after a fall. Ms F complained that her mother had been put in a side room, been forgotten by housekeeping services so her room was unhygienic, had not been given her medication properly, and that the family was not told that she had had a fall in hospital. Ms F said that the family found a tablet on the floor one day that Mrs Z had not taken. They were concerned about this but the Trust said it was a piece of plastic.

Mr F said the events during the last days of her mother's life haunt her and have affected her own life.

What we found

We partly upheld this complaint. The Trust failed to inform the family properly about Mrs Z's fall. It also failed to provide housekeeping services, and did not give her medications properly or record them.

However, it was reasonable to transfer Mrs Z to a side room to prevent the spread of infection as she had a bout of diarrhoea. We could not determine whether the item on the floor was plastic or a tablet.

Putting it right

The Trust acknowledged its failings and produced an action plan to address them.

Organisation(s) we investigated

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Location

Bournemouth

Region

South West

Summary 1186/December 2015

Trust followed good mental health practice

Mental health team provided appropriate care to patient who was at risk of self-harming.

What happened

Mr L was admitted to hospital in early summer 2013 because he had a high risk of self-harming. He was discharged around two weeks later. A month later he returned to hospital after harming himself. Nearly a year later he again self-harmed despite being seen by mental health staff at home. Mr L complained that he was not given the care and support he needed, especially when he left hospital the first time.

What we found

We partly upheld this complaint. The mental health team followed established good practice and the relevant guidelines in the way they treated Mr L.

There was one exception to this: Mr L sought help for his suicidal thoughts and the nurse he spoke to did not carry out a risk assessment despite clear evidence that Mr L was struggling. Mr L self-harmed shortly afterwards. We could not see that this assessment would necessarily have led to him not self-harming, but an opportunity was lost to provide him with support that could have led to a different outcome.

Aside from this incident we found that staff gave Mr L good care.

Putting it right

The Trust recognised the failings we found and the impact they had on Mr L. The Trust apologised to Mr L and took action to show that it had learned from the complaint.

Organisation(s) we investigated

Kent and Medway NHS and Social Care Partnership Trust

Location

Kent

Region

South East

Summary 1187/December 2015

Trust wrongly doubled insulin dose

The Trust drastically increased Mrs L's prescribed insulin dose and her medical records were not clear why this happened.

What happened

Mrs L was admitted to the Trust following a fall. Doctors diagnosed her with a fracture of her left fibular (leg bone) and fitted a cast below her knee. Staff transferred her to another of the Trust's hospitals for rehabilitation. While there, doctors increased Mrs L's prescribed insulin dose to approximately double what it had previously been because of her high blood sugar level. Mrs L refused to take this because she had concerns about whether the dose was safe, and it also caused her to worry about how the Trust was managing her diabetes.

While Mrs L was in hospital a healthcare assistant knocked a table into Mrs L's toe and doctors found that her toe was broken. Mrs L said the healthcare assistant's behaviour was unacceptable and Mrs L was unhappy with her attitude.

What we found

We partly upheld this complaint. There were failings in doubling Mrs L's insulin dose and the medical notes were not clear why this happened. We did not find failings with the attitude of the healthcare assistant, and Mrs L's toe was already broken when she was admitted, and this had showed up on X-rays taken at the time.

Putting it right

The Trust acknowledged its failings and apologised to Mrs L for the impact these had on her. It also produced an action plan to show how it would make sure the failings we found would not happen again.

Organisation(s) we investigated

Hillingdon Hospitals NHS Foundation Trust

Location

Greater London

Region

London

Summary 1188/December 2015

Poor end of life care

Hospital staff gave a man with mental health problems poor end of life care but this did not hasten his death.

What happened

Mr R had long-standing mental health problems and was under the care of the Mental Health Trust. He experienced severe side effects from his antipsychotic medication so his psychiatrist changed it. After a few months Mr R started to feel unwell and so the psychiatrist put him back on his original medication.

Mr R continued to experience problems so GPs from the Practice visited him at the nursing home where he lived. They treated him but decided against sending him to hospital.

Mr R eventually had to go to hospital (the Acute Trust) and while he was there doctors realised that he was reaching the end of his life. In his final days he had regular and prolonged seizures that were distressing for him and his family. He died in hospital after suffering a stroke.

His sister, Mrs Y, complained to all three organisations about the care and treatment they gave Mr R. She said the change in medication made her brother psychotic, that the GPs should have sent him to hospital sooner, and the failings in medical and nursing care at the Acute Trust contributed to the decline in her brother's health and possibly his death.

What we found

We partly upheld this complaint. We did not find any failings in care and treatment from either the Practice or the Mental Health Trust.

There were however, failings in the care and treatment staff at the Acute Trust gave to Mr R. Nurses failed to monitor his observations or refer his care to doctors, doctors failed to liaise with mental health professionals and did not give Mr R the medication he needed. Doctors also failed to involve Mrs Y in the 'do not resuscitate' process, gave Mr R active care when they should have given him palliative care only, and failed to involve hospital neurology services sufficiently.

None of the failings would have had any impact on the progression of Mr R's illness or his subsequent death. However, we could see how these failings would have been distressing for his sister who was already upset because of his illness.

Putting it right

The Acute Trust acknowledged its failings and apologised to Mrs Y for the injustice we found. It also took action to make sure the same failings do not happen again.

Organisation(s) we investigated

Epsom and St Helier University Hospitals NHS Trust (the Acute Trust)

Surrey and Borders Partnership NHS Foundation Trust (the Mental Health Trust)

A GP practice

Location

Surrey

Region

South East

Summary 1189/December 2015

Failings in care of a dying patient

Mr W's family complained about actions of doctors and nurses during the last few days of his life.

What happened

Mr W was terminally ill with idiopathic pulmonary fibrosis (scarring of the lungs that usually follows previous lung disease). He had been suffering with increased shortness of breath over several months. He went to hospital in early summer 2014 where doctors first treated him for a chest infection. During his stay in hospital his health worsened and he died five days later.

His family complained about a range of issues relating to care and treatment that doctors and nurses gave him. These were: the choice of ward during his admission; staff's knowledge about his condition; record keeping; personal care; pressure area care; observations; nutrition; mobility; medication; cannula care; end of life care; and anticoagulant therapy.

Although Mr W was terminally ill, his family did not believe he was at the end of his life when doctors admitted him to hospital. They said the trauma of what the family witnessed during Mr W's last hours was '*devastating*' and had '*lasting effects on the whole family*'.

The family were unhappy the Trust did not address all of their concerns or take action to follow up accepted failings, so they came to us.

What we found

We partly upheld this complaint. There were no failings in most of the areas that we looked into. We did find failings in anticoagulation management and cannula care, but these failings did not have any impact on Mr W.

However, there were failings in Mr W's end of life care on the day he died that added to the family's distress. Poor record keeping led to frustration for the family and poor complaint handling added to their worry.

Putting it right

The Trust acknowledged its failings and apologised to the family for the impact the failings had on them. It also put in place an action plan to show it had learned from the complaint.

Organisation(s) we investigated

University Hospitals of Morecambe Bay NHS Foundation Trust

Location

Lancashire

Region

North West

Summary 1190/December2015

Delays in diagnosing Asperger's syndrome

Because of the Trust's delay Mr P was not given the support that he needed.

What happened

Mr P's mother, Mrs L, initially suspected that her son had Asperger's syndrome (a form of autism) when he was a young boy, nearly 40 years ago. He was assessed but Asperger's syndrome was never diagnosed. In 2001 Mr P took an overdose and was referred to the mental health services at the Trust. Doctors treated him for depressive symptoms and discharged him four years later when his symptoms resolved.

In 2009 he was again referred to the Trust because of depressive symptoms and anxiety, and doctors treated him for a year until he was again discharged.

Three years later he was once more referred to the Trust and staff raised the possibility of Asperger's syndrome. They arranged for an assessment but this had still not been done after four months, so Mrs L decided to pay for the assessment to be done privately. The private psychologist diagnosed Asperger's syndrome and the Trust provided support for Mr P.

Mrs L said that she had to battle for her son to receive an assessment and this was exhausting and stressful for her. She said this had caused years of anxiety and led to Mr P being left vulnerable and at risk.

What we found

As Asperger's syndrome is a lifelong condition Mr P would have had the condition during each period he was treated by the Trust. Therefore staff missed the diagnosis. However, we found that in the earlier periods of Mr P's life, when the possibility of Asperger's syndrome was not raised, it would have been unreasonable to expect the Trust to have diagnosed it. He was seen by a generalist mental health team and at no stage did Mr P show symptoms that would cause a generalist team to consider the possibility of Asperger's syndrome.

However, when Mr P was referred to the Trust for the third time, the delay of five months in diagnosing Asperger's syndrome meant Mr P did not have the support that he needed during that period. This delay was also frustrating for Mrs L and caused her anxiety.

Because the Trust had already acknowledged that there was a delay and had apologised for this, we did not consider that any further actions were necessary and we therefore did not uphold this complaint

Organisation(s) we investigated

Norfolk and Suffolk NHS Foundation Trust

Location

Suffolk

Region

South East

Summary 1191/December 2015

Missing records left daughter concerned about mother's death

Mrs R's daughter did not know what caused her mother's sudden death, but the Trust's explanation was reasonable.

What happened

Mrs R had chronic leukaemia. In early 2012, she was admitted to hospital with back pain and symptoms of an infection. Doctors gave her morphine for her pain but she deteriorated and died the next day. Mrs R's daughter, Mrs P, said that a doctor had told her that Mrs R had been given too much morphine and she believed this contributed to her mother's death.

However, the records of Mrs R's hospital stay went missing after the Trust sent them to the coroner. This meant the Trust could not find out what treatment Mrs R had received or who had spoken to Mrs P. The Trust said that it was most likely that Mrs R's death was due to an infection. Mrs P said that the Trust had not done enough to find out what had happened in her mother's care or to identify the doctor who treated her mother. She said the Trust had not dealt with her complaint properly and so she came to us.

What we found

We partly upheld this complaint. It was not clear how the records went missing, or who was responsible, so we could not say that this was the Trust's fault. Without the records, we could not find out whether the amount of morphine doctors gave Mrs R was appropriate for her symptoms. But the available evidence did not show any problems that would have been caused by too much morphine, and the Trust's explanation about the likely cause of Mrs R's death was reasonable from a clinical perspective.

The Trust took too long to deal with Mrs P's complaint. It also had not made clear to Mrs P what it would do to try to identify the doctor she had spoken to. That led to Mrs P having disappointed expectations.

Putting it right

The Trust apologised to Mrs P for the distress she experienced as a result of the poor handling of her complaint.

Organisation(s) we investigated

Plymouth Hospitals NHS Trust

Location

Plymouth

Region

South West

Summary 1192/December2015

Not enough support for vulnerable young woman

Trust did not provide a support plan for Miss K when it discharged her from its crisis team.

What happened

Miss K was in her early twenties and referred to the Trust's mental health services because she was agitated, frightened and believed that her father, who had died 12 years before, was following her and trying to harm her.

She had thoughts of suicide so she was admitted by the crisis team to the Trust's mental health hospital where she was assessed. She stayed in hospital for a week and then she was discharged.

The crisis team visited her at home on a daily basis then reduced this to alternate days. The team advised her to complete an assessment form for the Trust's talking therapy service and then discharged her.

However, a few days later Miss K required urgent support and her friends called the crisis team who agreed to see Miss K the next day. The team's community psychiatric nurse assessed her a few days later but did not feel that Miss K showed any signs of psychosis so she did not need any further support.

Miss K went for her first appointment with the talking therapy service and she also saw a cognitive behavioural therapist. The therapist said that this was not the right service to help her, and she needed intensive treatment with the adult early intervention team. She was referred to that team and began support.

Miss K's mother, Mrs K, and Mrs K's partner, Mr C, complained that the Trust discharged Miss K from the crisis team without appropriate support or care plans in place, prescribed the wrong medication when she was in hospital, referred Miss K to the wrong therapy service, and that communication with the family was poor.

Mrs K and Mr C said this caused deterioration in Miss K's mental state and delayed her recovery. They said she had to stop working and was not able to socialise, and the experience was very stressful and upsetting for the whole family.

What we found

We partly upheld this complaint. It was reasonable to discharge Miss K from hospital to the crisis team. Miss K received appropriate support from the crisis team and it was reasonable to discharge her from the crisis team when staff considered that she no longer required its support.

It was acceptable for the crisis team to refer Miss K to the talking therapy service as staff thought it the best option for her at the time, and the medication the hospital doctors gave Miss K during this time was appropriate.

However, the crisis team should have given Miss K a crisis and contingency plan when it discharged her, and communication with Miss K's family was poor. This meant that Miss K did not know who to contact when she needed assistance, and her family did not know about or understand the treatment plan, which was very stressful for them.

Putting it right

The Trust apologised to the family and said that it had learned lessons from our investigation. It put in place plans to make sure that the failings we found would not be repeated.

Organisation(s) we investigated

Solent NHS Trust

Location

Southampton

Region

South East

Summary 1193/December 2015

Patient not kept up to date about her care

The Trust offered appropriate care, but failings in communication caused distress.

What happened

Mrs B's GP referred her to hospital because she had persistent pain in her heel. Doctors diagnosed her with an inflamed Achilles tendon and gave her injections to relieve the pain in early summer 2014.

The consultant referred her to another trust for further high volume injections and ultrasound treatment. But when Mrs B went to that trust's hospital for the treatment, staff said it was too soon after her previous treatment.

Mrs B was concerned that the consultant may have referred her for inappropriate treatment that could have damaged her health. She said the consultant had not told her about the further injections or that she was being referred for ultrasound. She then had to wait a long time for an appointment for ultrasound treatment at another local hospital to which the Trust referred her. She said she had lost confidence in the consultant.

She complained to the Trust twice but was unhappy with its responses so she came to us.

What we found

We partly upheld this complaint. There are no published standards for treating an inflamed Achilles tendon. The treatments the Trust offered were among those that are often used. Therefore, it was reasonable for the Trust to make these referrals for Mrs B. However, it did not tell her that it had referred her for ultrasound treatment. That was a failing.

The Trust's initial response to Mrs B's complaint inadequately addressed some of her concerns, and it relied heavily on comments from the consultant about whom she complained. The Trust should have arranged for a member of staff not directly involved to look at her complaint.

Putting it right

The Trust apologised to Mrs B for the upset she experienced as a result of its failure to keep her up to date about her care, and its poor handling of her complaint.

Organisation(s) we investigated

Plymouth Hospitals NHS Trust

Location

Plymouth

Region

South West

Summary 1194/December 2015

Cancer care was not in line with guidance or established good practice

When Mrs K's cancer came back, her locum consultant, Dr T, failed to treat her appropriately, meaning she experienced unnecessary pain and suffering in her last few weeks of life.

What happened

Mrs K was in her mid-forties when her cancer returned. Her oncologist, Dr A, set out a treatment plan that included a scan after three courses of chemotherapy to see if the tumours had stopped growing. Mrs K was part way through Dr A's treatment plan when Dr A went on maternity leave. Locum consultant Dr T took over Mrs K's care but he did not continue with Dr A's treatment plan.

While on holiday the next year Mrs K was in severe pain and admitted to a local hospital for emergency treatment. When she went home she was so ill she needed to be referred for palliative care to control her pain. Dr T referred her to Dr D for this and Dr D both changed and increased Mrs K's pain medication and recommended further changes to her postchemotherapy medication. Mrs K died later that year.

Mrs K's husband, Mr K, complained about the quality of care his late wife received while in the care of Dr T. He said she suffered unnecessary pain and believed she could have lived longer had she received better and earlier care. He said he and his three children were badly affected by Mrs K's premature death and that they received counselling as a result of this.

What we found

We partly upheld this complaint. Some aspects of the care Dr T and the Trust gave to Mrs K were not in line with recognised quality standards and established good practice. Most significantly there were delays in arranging CT scans and subsequent treatment; a lack of adequate pain control that would have improved Mrs K's quality of life; and the lack of a clear care plan that meant Mrs K received a completely inappropriate final chemotherapy injection, given how her disease had progressed.

Although the length of Mrs K's life could not have been extended, the quality of it could have been improved.

Mr K experienced considerable unnecessary anxiety and stress as he watched Mrs K suffer pain and distress that could have been avoided.

Putting it right

The Trust apologised to Mr K and paid him £1,000 to acknowledge the failings we found and for the impact they had on him. It put in place plans to learn lessons from its failings to make sure they didn't happen again.

Organisation(s) we investigated

The Clatterbridge Cancer Centre NHS Foundation Trust

Location

Merseyside

Region

North West

Summary 1195/December 2015

Trust loses hospital records of older patient

Mr Qs daughter was unhappy about her father's care in hospital, but when she complained the Trust had lost his records so could not respond properly to her concerns.

What happened

Mr Q was in his nineties and lived at home with the help of carers. He had increasing pain in his hip and was admitted to hospital in winter 2014. Doctors ruled out a hip fracture and organised an assessment of his mobility. Mr Q remained unwell and developed a chest infection a few days later, which meant his planned physiotherapy was delayed. He was discharged to a nursing home about three weeks later, but readmitted to hospital the same day because staff found him unresponsive in bed. Following tests he was discharged again two weeks later and sadly died at the nursing home two weeks after that, early in 2015.

His daughter, Mrs S, complained about the care and treatment her late father Mr Q received during the two months he was in hospital. Her main concerns were that the Trust did not consider him suitable for rehabilitation and that he acquired an infection in hospital. She said the Trust blamed his '*complicated medical issues*' on his condition.

Mrs S said that when she complained to the Trust it was unable to locate Mr Q's records, which meant there were several questions that it could not clearly resolve.

Mrs S said her father's deterioration and death could have been avoided if he had had better care. She was extremely distressed and angry about the care he received.

What we found

We partly upheld this complaint. Even without many of the records, we decided that on the balance of probabilities the care the Trust gave to Mr Q was in line with recognised quality standards and established good practice.

However, the Trust had failed to recognise the impact the missing records had on Mrs S. Also, because we could not investigate some of her complaints, Mrs S was left not knowing what had happened, or the impact this may have had on Mr Q.

Putting it right

The Trust wrote to Mrs S to apologise for the impact the loss of the records had on her.

Organisation(s) we investigated

East and North Hertfordshire NHS Trust

Location

Hertfordshire

Region

East

Summary 1196/December 2015

Hospital admits failings in older person's discharge

Mrs B's family raised several complaints about the arrangements when she was discharged from hospital to a nursing home.

What happened

Mrs B was in her late eighties and went to hospital for a short time to have surgery. When she was discharged staff gave her someone else's medicine and she did not have her hearing aids or handbag. Her discharge letter said that all her medication was to be stopped. The hospital did not tell the nursing home where she lived that she was being discharged, and did not dress Mrs B appropriately for the cold weather on the night she left hospital. Mrs B's family also complained that she was transferred in a car without a chaperone rather than in an ambulance. Mrs B died shortly afterwards.

The Trust wrote to Mrs B's family and also met with them. It acknowledged failings in every aspect of the complaint other than the decision to transfer Mrs B in a car without a chaperone. The Trust also said that many of the issues could have been avoided if the family had been allowed greater opportunity to help out with transporting Mrs B and prepare her for discharge.

The Trust apologised for the loss of Mrs B's hearing aids and said that these would have been replaced if Mrs B had not died shortly after she was discharged. The Trust said that it had recently fitted new lockers throughout the hospital to make sure patients' belongings were securely stored, made changes to the discharge summary letter template, and introduced new procedures to ensure medication is checked before patients are discharged.

Mrs B's son, Mr B, said that at a time close to the end of his mother's life she was not treated with respect and suffered uncertainty and poor care. He said the Trust did not provide a reasonable response to the family's complaint, so he came to us.

What we found

There were several shortcomings in the discharge arrangements but the Trust had already provided appropriate apologies and taken measures to prevent a recurrence. Therefore we did not uphold this complaint.

Organisation(s) we investigated

Wrightington, Wigan and Leigh NHS Foundation Trust

Location

Warrington

Region

North West

Summary 1197/December 2015

Trust discharged older patient in a poor condition

The Trust failed to give Mrs T enough to eat or drink, and on discharge did not check for skin sores or make proper arrangements for a follow up blood test.

What happened

Mrs T was in her late seventies and had a history of dementia and stroke. She was admitted to the Trust's hospital because her health was deteriorating, she was generally weak and not eating or drinking enough. Mrs T was diagnosed with a pulmonary embolism (blockage in the pulmonary artery, the blood vessel that carries blood from the heart to the lungs). She was treated with injections and later with warfarin (a blood thinning medication). While she was in hospital, Mrs T lost approximately 7kg over a month. When she was discharged home her daughter Mrs Y called the out-of-hours service because she was concerned that her mother had sores on her skin, which the Trust had not told her about. Also, Mrs T was discharged on a Friday and doctors at the Trust told her she needed a blood test with her GP on the Monday but did not alert the GP to this.

Mrs Y complained about the condition Mrs T was discharged in; her lack of personal care; that she was not given enough to eat or drink; and that there was poor communication about Mrs T's prognosis. Mrs Y was caused additional stress by having to chase the arrangements for the blood test.

Mrs Y said her mother's condition deteriorated while she was in hospital and her life cut short because of the poor care she received. She said she and her sister were distressed by these events.

What we found

We partly upheld this complaint. There were failings with the Trust's record keeping; the amount of food and drink Mrs T was given; the condition she was discharged in; and the Trust's communication with Mrs T's GP about her blood test.

Putting it right

The Trust acknowledged and apologised to Mrs Y for these failings and the impact these had on her and Mrs T. It produced an action plan explaining how it would make sure all the failings we found did not happen again.

Organisation(s) we investigated

Colchester Hospital University NHS Foundation Trust

Location

Essex

Region

East

Summary 1198/December 2015

Trust left it too late to diagnose and treat sepsis

When Mr L went to the Trust with a swollen eye, doctors failed to notice soon enough that he was becoming ill with sepsis.

What happened

Mr L was in his mid-eighties when he was taken to an urgent care centre with a swollen eye. He had a medical history of atrial fibrillation, hypertension, congestive cardiac failure and diet controlled type II diabetes. He had previously suffered two heart attacks.

Doctors provisionally diagnosed orbital cellulitis (an infection of the tissues around the eye) and gave him oral antibiotics. When his condition deteriorated he was transferred urgently to another hospital within the Trust for review and to start a course of intravenous antibiotics. He arrived at 9.30pm but, because of delays in A&E and the Medical Assessment Unit, he was not prescribed the antibiotics until 1.20am. Mr L was eventually given the antibiotics at 4am and 5am but he continued to deteriorate and died twelve hours later.

Mr L's daughter, Ms J, believed her father's death could have been avoided if he had received earlier treatment for his orbital cellulitis. She also complained about the way the Trust handled her complaint.

What we found

There were missed opportunities to diagnose and treat Mr L for his developing sepsis by both the A&E and Medical Assessment Unit staff.

Ms J will never know whether her father might have survived had he received earlier care.

The Trust also did not respond to Mr L's daughter's complaint in a reasonable manner.

Putting it right

The Trust acknowledged its failings and apologised to Ms J.

It also prepared an action plan to make sure these failings would not happen again.

Organisation(s) we investigated

Pennine Acute Hospitals NHS Trust

Location

Manchester

Region

North West

Summary 1199/December 2015

Poor care caused distress at end of life

A patient with heart problems was kept on a short stay ward without cardiology review or tests.

What happened

Mr G had a history of chronic asthma, chronic obstructive pulmonary disease and heart disease. He was admitted to hospital as he was very unwell with breathing problems. He was kept in a short stay ward without seeing his own asthma consultant (who did not know he was in hospital) for six days. When she saw him she was shocked by his condition as he was bent over, hardly able to speak, and his legs and feet were swollen. She asked for heart tests, but these were not done for two days. Mr G died the day after the tests from heart failure.

During Mr G's time in the short stay ward his wife, Mrs G, said it was not clear what his treatment plan was, and staff made attempts to mobilise him with a view to discharging him. This was very distressing for him as he was struggling to breathe.

Mrs G said the Trust did not admit its failings and did not explain why it did not carry out tests on Mr G's heart immediately. She said that the medical treatment he received was inadequate and contributed to his death.

What we found

There was a failure in service in Mr G's treatment. The physician in charge of his care in the ward did not record what she thought was actually wrong with him, and there was little evidence of clinical input.

There was also a failure in service in that staff did not carry out heart tests for a week, and that it was not appropriate to plan for Mr G's discharge.

These failings contributed to Mr G's distress and that of his wife as she had to witness his poor care. However, we could not say that the failings contributed to Mr G's death as he was already very unwell.

Putting it right

In the light of the failings we found, the Trust revisited the action plan it wrote in response to Mrs G's original complaint to it. The Trust told us and Mrs G how it would make sure that heart patients receive prompt assessment and treatment in future. The Trust apologised to Mrs G for the impact its failings had on her, and paid her £1,000 in recognition of this.

Organisation(s) we investigated

York Teaching Hospitals NHS Foundation Trust

Location

York

Region

Yorkshire and the Humber

Summary 1200/December 2015

Trust's incorrect diagnosis and poor complaint handling caused distress

Mr Z complained that the Trust misdiagnosed him as suffering from heart failure and that the doctor did not follow the relevant guidelines when making this diagnosis. He also complained that the Trust failed to adequately respond to his complaint.

What happened

Mr Z was admitted to the Trust with swollen legs, weight gain, shortness of breath and breathlessness when lying down. The Trust recorded that he was not regularly taking his heart medication because he was worried about the side effects. Mr Z was examined, treated and discharged with medication after two days.

Mr Z complained to the Trust that he was misdiagnosed as suffering from heart failure and that a respiratory medicine doctor had made this diagnosis rather than a cardiologist (doctor who specialises in heart conditions). He said that the respiratory doctor did not comply with the relevant guidelines when forming his opinion of heart failure and that the Trust did not carry out an echocardiogram (ECG – a scan used to look at the heart and nearby blood vessels) when it said it did.

Mr Z said he was discharged without proper investigations and with the wrong medication. He said he had experienced a longer period of symptoms, including headaches, vision difficulties, tiredness and swelling, than he should have done. He also said he had to take additional time off work with sickness. Mr Z said all of this had caused him pain and to suffer psychologically as well as emotionally. He also complained about the way his complaint had been handled.

The Trust responded to Mr Z's initial complaint, but despite confirming several times that it would address his follow-up concerns, it eventually declined to respond after a delay of nine months. Mr Z complained to us. He wanted an apology, service improvements and a payment.

What we found

We upheld this complaint. We found that while the Trust appropriately investigated and assessed Mr Z, it had drawn incorrect conclusions. The Trust claimed it had carried out an ECG but we found this had been done at another hospital and in fact the results had pointed away from a diagnosis of heart failure. We also found the Trust had carried out an X-ray, which showed no sign of heart failure. The notes of interaction between the respiratory doctor and Mr Z were also poorly recorded. Mr Z suffered the distress of an incorrect diagnosis, ongoing symptoms from his actual condition and the difficulty and inconvenience in arranging further investigations.

In relation to whether a cardiologist should have made the diagnosis rather than the respiratory doctor, we found that it was perfectly reasonable for a respiratory doctor to make such a diagnosis. However, because Mr Z was already under the care of a cardiologist, the Trust should have made sure that the cardiologist was made aware of its diagnosis. This was a failing.

The Trust's handling of this complaint was very poor and meant that Mr Z did not get answers to the many questions he had asked. The Trust's initial response contained a number of unexplained clinical terms, which did not reasonably address the complaint. The Trust then took nine months before it told Mr Z that it would not be fulfilling its commitment to respond. We concluded that the Trust's complaint handling fell so far short of acceptable standards that we regarded this as a serious failing.

Putting it right

The Trust acknowledged and apologised to Mr Z for the incorrect diagnosis and various other failings in his care and treatment, and for the poor handling of his complaint. It asked the consultant involved in the diagnosis to review his practice in light of the facts we established. The Trust also paid Mr Z £1,250 in recognition of the distress, pain and inconvenience he experienced because of the incorrect diagnosis and poor complaint handling.

Organisation(s) we investigated

London North West Healthcare NHS Trust

Location

Greater London

Region

London

Summary 1201/December 2015

Trust did not make referral to palliative care services

The Trust treated Mrs K appropriately but failed to refer her to palliative care services when it considered she was too ill to have treatment for suspected lung cancer. Mrs K's husband, Mr K, said palliative care services could have offered additional help and support to him and his wife.

What happened

Mrs K had several medical problems including diverticulitis (inflammation of the bowel), arthritis and chronic breathlessness. In 2005 she had an operation to remove her gallbladder. In 2012 she was diagnosed with breast cancer. Mrs K had surgery followed by radiotherapy and chemotherapy at the Trust. She also had regular appointments at the Trust in 2013.

In early 2014, a scan showed that Mrs K had a lump in her lung, and stones in her bile duct. She had three procedures to remove the stones from her bile duct. Mr K said the doctors thought the lump in her lung was likely to be cancer, but the Trust decided Mrs K was not well enough to undergo the treatment she would need to diagnose and treat it. Mrs K died of lung cancer at home in summer 2014.

Mr K complained to the Trust about his wife's care. He said that the stones must have been in Mrs K's bile duct for a long time, and the hospital should have seen them. He said that the persistence of Mrs K's symptoms and the frequency of her attendances at hospital meant that staff should have been able to diagnose the stones sooner. He felt the stones may have weakened Mrs K. He also complained about the specialist Mrs K saw about the lump in her lung.

The Trust responded to his complaint and said that it was not unusual for stones to form in the bile duct of someone who had previously had their gall bladder removed. It also sent Mr K some further explanations.

Mr K remained concerned, and complained to us.

What we found

We partly upheld this complaint. We found that although Mrs K had had numerous scans, none of them gave doctors a reason to suspect she had stones in her bile duct. When they found the stones, the doctors treated Mrs K appropriately. We found that the lung specialist was right to say that Mrs K was too unwell to go through procedures to diagnose and treat lung cancer. However, because the Trust was not able to offer any other treatment, the lung specialist should have referred Mrs K to palliative care services, which could have offered additional help and support to Mr and Mrs K.

Putting it right

The Trust apologised to Mr K and drew up an action plan to show how it would make sure appropriate referrals were made to palliative care in future.

Organisation(s) we investigated

East Kent Hospitals University NHS Foundation Trust

Location

Kent

Region

South East

Summary 1202/December 2015

Trust's poor communication led to raised expectations about scar surgery

Miss E complained that the Trust failed to communicate with her in a timely or accurate way regarding the planning and funding of the surgical procedure to remove a growth (keloid scar) on her son's earlobe.

What happened

After having his earlobe pierced, Miss E' son, B, developed a growth (a keloid scar) at the back of his ear. His GP referred him for maxillofacial surgery at the Trust.

In autumn 2014 after an examination, the Trust said that an operation was necessary to remove the growth. However, Miss E said that the Trust did not tell her that this procedure was no longer available on the NHS as a routine procedure and that the Trust would have to get funding approval from the Clinical Commissioning Group (CCG). Miss E called the Trust two months later and the Trust said the operation would go ahead in late 2014. Despite chase-up calls, it did not provide a date for the operation.

In early 2015 the Trust told Miss E that the reason it had not given her a date was because it had not received funding approval for the operation. The Trust then submitted a request for funding to the CCG.

However, the CCG declined the request for funding. It said it did not fund procedures carried out for cosmetic reasons and a keloid scar operation was among such procedures.

It advised the Trust that funding may be considered through the Individual Funding Request (IFR) route in exceptional clinical circumstances. The Trust submitted another request for funding through the IFR route, including photographic evidence, but the CCG again declined saying that there were no grounds for clinical exceptionality to deviate from its policy not to fund cosmetic interventions. Miss E appealed the decision but the CCG said that the new information that Miss E had given did not constitute strong enough grounds for review by an Appeal Panel.

Miss E complained to the Trust and it apologised for not explaining the process earlier to her. But Miss E remained dissatisfied and came to us. She said the Trust had not communicated with her in a timely or accurate way regarding the planning and funding of the surgical procedure. She also complained that the CCG hadn't properly considered the application for funding and the suffering caused to her son. As a result, Miss E said B was left distressed and selfconscious about the growth and was at risk of bullying.

Miss E wanted the CCG to agree to fund the procedure. She also wanted the Trust to improve its communication with patients and families.

What we found

We partly upheld this complaint. The CCG had discretion to make decisions about what it would or would not fund. It had looked at all the available information and considered appropriately whether there was any clinical exceptionality that would mean it should fund B's surgery. We found no failings here.

However, over four or five months, the Trust incorrectly raised the expectations of B and his mother about the surgery taking place. Communication was poor and there was also a delay in the Trust requesting the necessary funding from the CCG.

The Trust had already acknowledged and apologised for these failings up to a point. Although we could not say that the distress caused to B and his mother was totally due to the actions of the Trust, it was reasonable to suggest that they did contribute to the unnecessary distress. So we made some recommendations to address this.

We did not uphold the complaint about the CCG.

Putting it right

The Trust acknowledged, and apologised for the failings and the distress caused, and paid Miss E £400. It also explained what it had done to improve things.

Organisation(s) we investigated

London North West Healthcare NHS Trust

North West London Collaboration of Clinical Commissioning Groups (CCGs)

Location

Greater London

Region

London

Summary 1203/December 2015

Cancer patient waited for five hours to see a doctor following a planned readmission

A woman complained about the care and treatment that her terminally ill father received when he went to hospital on two occasions.

What happened

Mr L had advanced terminal lung cancer, with secondary cancer to his brain, and had just finished a course of radiotherapy. He also had chronic obstructive pulmonary disease. In autumn 2014 he collapsed at home and his family called an ambulance. A doctor from the emergency department assessed him and took a detailed history from him. The doctor noted that Mr L was coughing and felt light headed. There were no signs of fever or shortness of breath. The doctor suspected that Mr L had pneumonia and arranged for a colleague from the oncology department to see him.

Mr L's daughter, Miss L said that a specialist nurse from the oncology team examined and assessed Mr L. She recorded that he looked well and she planned to discharge him home with antibiotics. She advised Mr L to return if his symptoms got worse.

Two days later, Mr L returned to the Trust by ambulance following a GP referral. He was suffering from breathlessness and a cough. Records showed that nurses felt Mr L did not need emergency attention but they had advised doctors that he was at the hospital. Nursing records also showed that necessary observations were taken while Mr L waited to see a doctor.

Five hours later, a doctor reviewed Mr L and he was admitted. Mr L was later transferred to a respiratory ward under the care of a respiratory consultant.

However, the following day Mr L's condition deteriorated and the respiratory consultant completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. He said resuscitation was unlikely to be successful for Mr L. He noted that he did not discuss the decision with Mr L or his family. But he made a note that he needed to speak to the family. Unfortunately, Mr L died shortly after that from pneumonia following on from lung cancer.

Miss L complained to the Trust about the medical and nursing care given to her father. She felt that if he had stayed in hospital on the first visit, he might have lived longer. She also complained that her father waited a long time on readmission following a referral from his GP. Miss L also said the family were not involved in the DNACPR decision and wereconcerned about how Mr L's health had declined so quickly. Miss L said her father died without any members of his family with him because of poor communication. She wanted the Trust to recognise its failings, apologise and make a payment for the distress caused.

The Trust accepted that there had been inaccuracies and apologised to Miss L. But she remained unhappy and brought the complaint to us.

What we found

We partly upheld this complaint. Trust staff made an appropriate decision to discharge Mr L on his first visit to hospital and followed the relevant guidelines and established good practice.

When Mr L was readmitted he waited for around five hours to see a doctor. The usual targets for patients waiting in A&E should not have applied because Mr L's GP had referred him to urgently see a doctor under the care of the medical team. We found that when doctors failed to attend despite being asked to do so, the nurses should have escalated matters to make sure Mr L was seen and treated urgently.

However, we did not find evidence that the delay had any impact on Mr L's health because his observations remained stable throughout that period, or that it contributed to the decline in his health later on. But we found that Mr L and his family went to the Trust expecting to see a doctor and then had to wait five hours for a doctor to attend. This was a failing because A&E staff did not follow established good practice when they did not ensure that a doctor reviewed Mr L and instead kept him in the emergency department for several hours. This must have been uncomfortable and frustrating for Mr L and his family.

In relation to the DNACPR decision, the respiratory consultant said that he would ideally have discussed the decision with Mr L, but he was too unwell for this to happen. He said it would also have been polite to discuss his decision with the family but there were no family members present at the time and it would not have been appropriate to discuss this issue on the phone. He said resuscitation would have been futile and even if he had met the family he would not have changed his mind.

We considered that the respiratory consultant had made an appropriate decision in this case. We found that resuscitation was unlikely to have been of any benefit to Mr L and could have caused him more distress. Therefore, the respiratory consultant had followed the relevant guidelines.

We did not find significant failings in the hours before Mr L's death because Trust staff could not have anticipated the decline in his health. We also did not find any failings in the way nurses communicated with Mr L's family.

Putting it right

The Trust acknowledged its failings and apologised to Miss L for the impact they had on Mr L and his family. It also produced an action plan showing what it had learned from the complaint.

Organisation(s) we investigated

Central Manchester University Hospitals NHS Foundation Trust

Location

Greater Manchester

Region

North West

Summary 1204/December 2015

Trust failed to give patient prescribed medication but this did not lead to her death

The failure to prescribe the correct medication and the lack of communication regarding this, led to a reduction in Mrs T's quality of life in the last few weeks before she died. Her family were left frustrated and distressed by the inaction of the Trust.

What happened

Mrs T's GP was treating her for a chest infection and possible urine infection. Towards the end of 2013 Mrs T's daughter, Mrs F, called for an out-of-hours doctor to see her mother as she had developed diarrhoea and felt unwell. However, instead Mrs T was taken to A&E at the Trust. The Trust carried out various tests and X-rays and admitted Mrs T while waiting for the test results.

Mrs F said that during the admission her mother became more agitated and confused, she developed withdrawal symptoms and experienced cramps in her limbs. Mrs F said she discovered that during that time the Trust had not given Mrs T her daily dose of two types of medication that her GP had prescribed to her for more than ten years previously. She said that the family raised this as a concern with the medical and nursing staff on three occasions, but the Trust did not take any action.

The Trust discharged Mrs T home without giving her the relevant medication. But when Mrs T got home, she had some medication which was there and Mrs F started giving it to her again. However, Mrs F said that her mother was very weak and could not walk or feed herself, and her condition deteriorated until she died ten days later.

Mrs F complained to the Trust, asking why the medication was not given and why this was not discussed with the family. The Trust responded saying that one of the medicines was not given because there was a letter from the GP on its file that said Mrs T had an intolerance to a similar drug. However, the Trust acknowledged that it should have checked this with the GP. It also said that it did not know why the other medication was not given.

Following further complaints and a meeting to discuss the outstanding concerns, Mrs F remained unhappy and brought the complaint to us. She said the withholding of her mother's medication contributed to the deterioration in her condition and her subsequent death ten days after discharge.

What we found

We partly upheld this complaint. The Trust did not follow the relevant guidance or established good practice when it failed to give Mrs T the correct medication. There should have been clear communication with Mrs T's family about why the Trust had not given Mrs T the relevant medication. We could not say that this contributed to Mrs T's death as she still continued to deteriorate when she returned home and started taking the medication again.

However, because Mrs T experienced withdrawal symptoms from not taking the medication, we said this led to a reduction in her quality of life in the last weeks of her life. Mrs T's daughters were left frustrated and distressed by the inaction of the Trust. Even though we saw that the Trust had acknowledged these failings, we considered that it did not acknowledge the significance of them and we felt that work was needed to make sure that the failings were not repeated.

Putting it right

The Trust produced an action plan identifying the lessons that it had learned from our investigation and explained how it would make sure that these failings would not be repeated.

Organisation(s) we investigated

University Hospitals Coventry and Warwickshire NHS Trust

Location

Coventry

Region

West Midlands

Summary 1205/December 2015

Poor record keeping meant Trust could not deal appropriately with complaint

Mrs A complained about the care and treatment given to her daughter, Ms P. But the Trust's lack of adequate record keeping meant that it could not support its complaint response.

What happened

Ms P had an eleven-year history of progressive multiple sclerosis (MS). When she was admitted to A&E at the Trust, she had not been eating or drinking, she was losing weight and she was suffering from pain, particularly in her shoulder. Ms P also had three bed sores, one of which was infected and needed antibiotics.

Mrs A complained to the Trust on behalf of Ms P about the care and treatment she received after being admitted to the Trust with bed sores. Mrs A complained about communication between the Trust and her family, and about a safeguarding alert that the Trust had implemented, which she felt seemed to suggest that her daughter needed protection from her and her husband. She said the Trust also delayed arranging a care plan for Ms A and the nursing care was poor. She said Ms A had become distressed and depressed due to the amount of time she spent in hospital and from the safeguarding alert that had been issued against her mother and father.

Mrs A also complained that Ms A was not being turned regularly, which meant she was left in the same position for longer periods of time. Mrs A was also not happy that the Trust had accused her of repositioning Ms A when the Trust had told her not to.

Mrs A said that at one point it took nurses 25 minutes to attend to Ms A when she had vomited.

The Trust responded to Mrs A's concerns and said Ms A was repositioned regularly. But Mrs A remained unhappy and brought the complaint to us.

What we found

We partly upheld this complaint. The Trust's records did not provide evidence to support its view that Ms A was turned at regular and appropriate intervals. There was an absence of supporting entries on the repositioning charts and some charts were incomplete. Ms A was not turned regularly as the Trust repeatedly recorded her as being in the same position.

We did not find evidence to support the Trust's claim that Mrs A had repositioned Ms A despite the Trust discussing this with her. Mrs A denied repositioning her daughter but acknowledged that she had changed her position if she had slipped or was uncomfortable. She also denied being spoken to about this by nursing staff.

With regard to the safeguarding alert, the Trust explained that it had raised it to make sure that Ms A received the best possible care from the NHS. It apologised to Mrs A if there was anything in its process that led her to believe the safeguarding alert implied criticism of her and her husband. We found the Trust's response was appropriate in this instance. The Trust also apologised for a single delay in answering a call bell, which we considered was reasonable.

Putting it right

The Trust apologised for not repositioning Ms A regularly. It also produced an action plan describing what it had learned from the failing we identified and how it would avoid a recurrence in future.

Organisation(s) we investigated

University Hospitals Coventry and Warwickshire NHS Trust

Location

Coventry

Region

West Midlands

Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033

Fax: 0300 061 4000

www.ombudsman.org.uk

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