Parliamentary and Health Service Ombudsman

Investigation reports concerning the University Hospitals of Morecambe Bay NHS Foundation Trust

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and Health Service
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Foreword

The investigations in this report follow the avoidable death of a baby. Our investigations are about a father's attempts to find out what happened and his desire to improve patient safety, to prevent the same thing happening to others.

The Trust could only achieve these things if they answered the family's questions openly and honestly and learnt from what they found.

We have concluded that the Trust did not do this. This is particularly unacceptable when an avoidable death was the cause of the complaints. The fact that the early records were missing compounded the problem.

The care and treatment provided to the baby was the subject of an inquest in 2011 and at the inquest, the events that had taken place became clear. Our investigations were not into the care of the baby, but were about the handling of complaints following this avoidable death.

This report includes the results of our investigations of four complaints from the baby's Father, and one from the baby's Grandfather. All five complaints are about the University Hospitals of Morecambe Bay NHS Foundation Trust and relate to the way in which the Trust handled the family's complaints. The complaints we investigated focused on inappropriate email exchanges, the investigations the Trust carried out into the death of the baby and an allegation of collusion amongst midwives about the fluctuation of the baby's temperature in preparation for the inquest.

We are publishing these reports because we believe there is wider learning for NHS providers.

We have upheld three of the four complaints made to us by the baby's Father. We have not upheld the complaint made to us by the baby's Grandfather.

We also investigated and upheld a complaint from the baby's Father about North West Strategic Health Authority. This concerned how they investigated events at the Trust. We published this report in December 2013 along with our report *Midwifery supervision and regulation: recommendations for change*.

Our view

Looking at all of the complaints together, they demonstrate that a lack of openness by the Trust and the quality of their investigations of these complaints caused a loss of trust and further pain for the family.

Our report *Designing Good Together*, published in 2013, was the result of research with patients, complaint handlers and clinicians and set out what needs to change in hospital complaint handling. In the report, we highlighted the need to overcome the defensive response of hospitals to complaints. This is essential if:

- Patients and their families are to feel confident their concerns and complaints are properly addressed;
- Hospitals are to learn from complaints and improve services for all; and
- Public trust and confidence in a hospital is to be restored.

The relationship between this family and the Trust is a further sad example of the need for this cultural change.

Recommendations for change

Our view is that these investigations reinforce the conclusions that we and others have made about the NHS complaints system. Change is needed in hospitals, in the way investigations are conducted and in the wider health and social care complaints system. At the Parliamentary and Health Service Ombudsman, we are changing our approach too.

Change for hospitals

Cultural change is needed from the ward to the board. Openness and learning must be strongly led and must start with definitive action by hospital boards. Hospital boards should:

- Establish expectations of openness and honesty, seeking feedback in order to learn and improve. They should reward staff who seek and respond well to concerns and complaints, including acknowledging mistakes. This will foster a new culture of remedy and learning.
- Use the ability within the complaints regulations to commission independent investigations if:
  - *'a complaint amounts to an allegation of a serious untoward incident;*
  - *the subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;*
  - *a complaint raises substantive issues of professional misconduct or the performance of senior managers;*
  - *a complaint involves issues about the nature and extent of the services commissioned.'*

This was recommended by the *Mid Staffordshire NHS Trust Public Inquiry*[1] and the government's response *Hard Truths*[2] and echoed by the recent *Review of the Handling of Complaints in NHS Hospitals – Putting Patients Back in the Picture*.[3]

- *Use board scrutiny of insight from complaints to drive a learning culture and ensure action is taken to learn and improve services for all.*
- *Be accountable to commissioners and the wider public for complaint resolution, learning and improvement through regular communication of outcomes and learning.*

Change for investigations

Looking at the root cause of the problem that leads to a complaint and the interactions between people involved are critical tools in helping to learn from complaints. The science of Human Factors seeks to understand the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour. We will expect these tools to be used in future independent investigations.

Organisations commissioning independent investigations should:

- Use Human Factors and Root Cause Analysis to get to the root cause of service failure.

At the Parliamentary and Health Service Ombudsman we have signed up to the National Quality Board's *Human Factors in Healthcare* Concordat. This commits us and others to communicate with commissioners and providers to increase their awareness and understanding of the concept of Human Factors, highlighting how the approach can be used to drive improvement in quality and safety.

This means that we will:

- Develop our expertise to use Human Factors science and Root Cause Analysis to learn from complaints and to understand better why mistakes happen, in order to facilitate learning.
- Encourage the widespread use of these tools in investigations following potentially preventable deaths and other serious incidents.

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1 The Mid Staffordshire NHS Foundation Trust Public Inquiry www.midstaffspublicinquiry.com/report

2 Hard Truths: the journey to putting patients first. Volume one of the government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

3 A review of the NHS hospital complaints system. Putting patients back in the picture. Final report. www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

The NHS and other providers should:

- Support the development of curricula, training frameworks and continuing professional development that ensure that the current and future workforce has the right skills, values and behaviours in relation to Human Factors principles and practices.

Changes in the wider NHS and social care

Change is already planned in the way health and social care complaints are dealt with following *Hard Truths*, the Government's response to the Francis report.

The Parliamentary and Health Service Ombudsman is working with the Department of Health, NHS England and other relevant organisations to help them improve complaint handling. This includes working with Healthwatch England to develop a vision and expectations for complaint handling across the NHS and social care. This work will only have an impact, however, if health and social care commissioners, providers, regulators and users align themselves with the new approach.

Changes for the Parliamentary and Health Service Ombudsman

We have learnt from our own handling of the Father's complaints to us along with feedback from other complainants following the potentially preventable death of a family member.

In 2010 my predecessor declined to investigate the Father's first complaint. In the light of new evidence from the coroner's inquest, we later accepted for investigation the elements of this original complaint that were still outstanding. The result is included in this set of reports. Although the decision made at the time was lawful, with the benefit of feedback from the complainant and others, it is not a decision that we would make today. We recognise that had we investigated, this family might have had answers to some of their questions regarding what happened to their baby sooner than they did. We are sorry for the impact that has had on the Father and his family.

In December 2013 we published the final result of another investigation into a complaint by this family, alongside our report *Midwifery supervision and regulation: recommendations for change*. We have acknowledged that our initial 2011 decision on this complaint was flawed and have apologised that it took so long for the family to get the answers they sought.

Feedback from complainants has had profound impact on our service. As a result of this feedback, we commissioned a review by Baroness Rennie Fritchie of our approach to complaints about deaths that potentially could have been avoided. We accepted all of her recommendations and since February 2013 we have begun our consideration of any complaint about the death of a loved one that could potentially have been avoided with the presumption that it will be investigated.

We have further changed our approach so that we can give more people our service. Investigating more complaints also means we share more learning and insight with service providers to enable them to learn and improve.

We are now seeing the impact of this change. We are investigating more cases than ever before and have stated our ambition to investigate around 4,000 cases a year, with a view to resolving more in the longer term.

As the final stage for complaints about NHS services in England, we continually challenge ourselves to learn and improve in the same way that we challenge others involved in the complaints system. Our vision is for complaints to make a difference and to help improve public services for everyone.

Dame Julie Mellor, DBE
Health Service Ombudsman

February 2014

Complaint about the investigation of complaints

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The complaint

1. We have investigated Mr D's complaint that University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust) failed to investigate adequately the events surrounding his son G's death.

2. Mr D complained about the first external report that the Trust commissioned in December 2008. He complained that the report was said to be '*external*' but that in fact one of the authors of the report was '*a friend*' of the chief executive of the Trust at the time. He also complained that the report was littered with typographical and presentation errors and left many of his questions unanswered. Further, Mr D complained that he was repeatedly told by the Trust that there were no discrepancies between the statements from staff and his and his wife's recollection of G's condition at birth, and the care provided for him. He complained that in fact, when he eventually obtained the statements, he saw significant differences. Mr D said that, in addition, he had seen evidence which suggested that further, more comprehensive, statements were prepared in order for staff to '*cover up the negligence that led to* [G's] *death*' and that these were subsequently destroyed before the inquest.

3. Mr D said that all these actions compounded his distress, and this was exacerbated by the fact that the second external report commissioned by the Trust[1] was not shared with the Care Quality Commission[2] (CQC) or Monitor.[3]

4. Mr D believes that the Trust have failed to learn lessons which would ensure that these failings do not occur again. He said he would like our investigation to establish any failings in the way the Trust investigated his complaint about the death of his son and ensure that any systemic failings we identify in the Trust's complaint handling are put right so that they are not repeated.

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1 Later referred to as the Fielding report.

2 The CQC is the independent regulator of all health and social services in England.

3 Monitor has an ongoing role in assessing NHS trusts for foundation trust status and for ensuring that foundation trusts are well led, in terms of both quality and finances.

The decision

5. I have found maladministration in the way in which the Trust investigated the events surrounding G's death. The statements taken as part of the root cause analysis process were not detailed enough. Those statements were not challenged and staff were not re-interviewed by the external reviewers when they were made aware of the differences between these statements and Mr and Mrs D's recollections of G's birth and postnatal care. In addition, I have found that the Trust inappropriately refused to disclose statements which had been provided by staff, even though the Trust knew that these were subject to the provisions on disclosure in the *Data Protection Act 1998* (the Act).

6. I have also found that an injustice to Mr D arose in consequence of this maladministration. I therefore uphold Mr D's complaint about the Trust. I have made recommendations and I am satisfied that, once complied with, these recommendations will provide a suitable response to what has happened. I explain why in this report.

Our role and approach to considering complaints

7. Our role[4] is to consider complaints about the NHS in England. We start by considering whether there is evidence that there has been maladministration by an NHS organisation, a failure in a service it provided or a failure to provide a service it was empowered to provide. If so, we consider whether that led to an injustice or hardship.

Powers to obtain information

8. The law allows us to ask anyone to give us information or documents needed for our investigation. They must provide that information.

How we decided whether to uphold this complaint

9. When considering a complaint we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.

10. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure. We then consider whether that has led to an injustice or hardship that has not been put right. If we find an injustice that has not been put right, we will recommend action. Our recommendations might include asking the organisation to apologise or to

4 Our role is formally set out in the *Health Service Commissioners Act 1993*.

pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation take action to stop the same mistakes happening again.

The relevant standards in this case

Our Principles

11. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[5] are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.

12. Three of the Principles of Good Complaint Handling particularly relevant to this complaint are:

    - '*Being open and accountable*' – which includes providing honest, evidence-based explanations and giving reasons for decisions;
    - '*Acting fairly and proportionately*' – which includes investigating complaints thoroughly and fairly to establish the facts of the case; and
    - '*Putting things right*' – which includes acknowledging mistakes and apologising where appropriate.

13. In addition to these Principles, there are specific standards which are relevant to our investigation of this case.

5 You can find more detail about our Principles at: www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples.

The specific standards

14. Section 7 of the Act sets out an individual's right of access to personal data. The Information Commissioner's Office has produced guidance on how this provision of the Act should apply. It states that:

> *'If a request does not mention the Act specifically or even say that it is a subject access request, it is nevertheless valid and should be treated as such if it is clear that the individual is asking for their own personal data.'*

15. It also says that '*a request is valid even if the individual has not sent it directly to the person who normally deals with such requests*'.

16. The guidance says that a request made under the Act should be responded to within 40 calendar days. This is also set out in section 7(8) of the Act.

The investigation

17. We confirmed the scope of our investigation with Mr D and the Trust on 15 March 2013 and in that same letter, explained how we would investigate the complaint.

18. During this investigation, we have considered relevant documents about Mr D's complaint, including documents relating to the attempts to resolve the complaint at a local level.

19. I have not included in this report everything we looked at during the investigation, but I have included everything important to the complaint and to my findings.

Background

20. The events complained about relate to Mrs D's second pregnancy and the birth of her son G. She did not have any complications during her first pregnancy and gave birth to a healthy baby girl.

21. Mrs D's waters broke on 25 October 2008 and she and her husband went to Furness General Hospital (the Hospital) that evening at approximately 10.50pm. Mr D has told us that in the week before G's birth, he and his wife had felt unwell. He said that they had both experienced headaches and sore throats, and that they explained this to the midwives at the Hospital. These discussions are not documented in Mrs D's notes made by the Trust.

22. On 25 October two sets of observations were carried out on Mrs D, which included measuring her blood pressure, pulse and temperature, and palpating her uterus in order to feel the position of the baby inside. She was told to return the following morning. When she returned on the morning of 26 October, it was documented in Mrs D's notes that she was not yet experiencing contractions, and that she had a mild headache, possibly because she had not slept well the night before. Mrs D was again advised to return the following day.

23. Very early on the morning of 27 October Mrs D began to have contractions and she returned to the Hospital. G was born shortly afterwards, at approximately 7.38am. The notes describe his birth as a '*normal delivery*' and they say that he '*cried immediately*' and was given an APGAR score of nine,[6] although when this was repeated five minutes later, his score was reduced to eight. This was because G's breathing was '*shallow*' and he was therefore taken to the resuscitaire.[7] His score after a further five minutes had increased to ten.

24. Mr D recalls G's birth differently. He says that when he was born, G seemed to struggle with his breathing, and he appeared blue and did not cry. He said that he was taken to one side by one of the midwives, who rubbed his chest. When that did not help him improve, the midwife gave him some oxygen. Mr D said that it was only after this that G improved quickly, and he cried and became pink.

25. The first 25 hours of G's life are poorly documented, because the chart that detailed his observations in those hours went missing around the time G was transferred to St Mary's Hospital (part of Central Manchester University NHS Foundation Trust). What is documented is that at approximately 8.30am on 27 October, Mr D approached staff and said that Mrs D had been feeling unwell, and felt cold and shivery. When her temperature was taken, it was 38.2°C,[8] and intravenous antibiotics and paracetamol were started shortly afterwards.

26. Mr D has told us that he became concerned about G because his wife was unwell. He said that both he and Mrs D were told not to worry by Trust staff as G '*looked fine*', that the paediatrician was

6 An APGAR score assesses the health of a newborn baby. It includes five criteria; skin colour, pulse rate, reflex irritability, muscle tone and breathing. Each criterion is given a score of 0 to 2. The maximum score is 10, which means the baby is perfectly healthy.

7 A specialist unit for babies who need a little help with their breathing.

8 Normal body temperature in an adult may vary, but is usually between 36.5°C and 37.4°C.

'*too busy*' to see him but that G was being monitored closely. Mr D said that G was mucousy, breathing quickly and wheezing. He said that none of the midwives seemed aware that Mrs D was being given antibiotics, and each time he felt he had to explain the situation to them. Mr D said that he asked whether antibiotics were needed for G, but this was dismissed because his temperature was low. He said that he was repeatedly reassured that if G had been suffering from an infection, his temperature would have been high.

27. Without the observation chart, we do not know exactly when G's temperature was taken or what the readings were. However, Mrs D recalls knocking over the observation chart at some point, and seeing entries that reflected that his temperature was 35.8°C and 36.1°C. What we know from the records is that G's temperature fluctuated to the extent that the midwives felt it necessary to transfer him to a heated cot at least twice. The last time was shortly before he collapsed.

28. At around 8.30am on 28 October Mrs D became very concerned about G's condition, and he was seen by a paediatrician for the first time. His condition continued to deteriorate and he was transferred to two different trusts for intensive treatment. On 5 November 2008 G sadly died from pneumococcal septicaemia.[9]

Root cause analysis

29. A root cause analysis[10] of the care provided for G was undertaken between November 2008 and January 2009. This analysis included statements taken from staff.

30. The statements from staff set out some of the detail of G's birth and subsequent condition. The midwife involved in G's birth recalled that he '*cried immediately*' and that he was given an APGAR score of nine, with a point having been deducted because he had *'blue extremities'*. The midwife said his APGAR score was eight after five minutes because his respirations were '*shallow*' and '*irregular'* and his '*muscle tone was not as good as when he was first born*'. She said that for this reason she took him to the resuscitaire, inviting Mr D to come with her, and gave G oxygen. At this point he cried immediately, went pink and was then given an APGAR score of ten.

31. One of the midwives caring for Mrs D said that, soon after Mrs D felt ill following G's birth, she had called the on-call paediatrician and told him about Mrs D's history of prolonged rupture of membranes (waters breaking) and raised temperature after G's delivery, and that she had felt unwell. The midwife said that the paediatrician told her that he was happy for midwives to observe the baby, and nothing else was ordered. The sister in charge remembered this call slightly differently, and said that '*in view of the sudden onset post delivery of maternal pyrexia*[11] [the midwife] *asked if*

9 Blood poisoning as a result of an infection caused by a bacterium called *Streptococcus pneumoniae*.

10 A root cause analysis is a well-recognised method of problem solving. It is designed to identify the causes of a patient safety incident in order to help ensure that such incidents are not repeated.

11 This is a body temperature that is higher than 37.5°C.

we should get the baby reviewed by the paediatrician, I agreed'. She said that the midwife then called the paediatrician and G was placed on four-hourly observations. The midwife who saw G after he had collapsed on the morning of 28 October said that in fact, his observation chart was '*three hourly*' (in other words, observations were to be done every three hours). The paediatrician who examined G following his collapse said in his statement that the midwife had explained to G's parents that '[G's] *circumstances had been explained* [to the paediatricians] *and advice was given to monitor every hour*'.

32. In relation to G's condition after his birth, one of the midwives recalled his temperature being '*low*' and that she put him in a cot warmer on the evening of 27 October. She thought that his low temperature was as a result of the room being cold. Another midwife recalled that, on the morning of 28 October, G's observations were all '*within normal limits*', but his temperature had dropped by 0.2 or 0.3 degrees. She said that she placed him in a cot warmer again, because she also felt the room was cold. She said she explained to Mrs D that if G did not maintain his temperature, he would need to be seen by a paediatrician.

33. The root cause analysis report broadly concluded that:

    - '*a review of the baby would have been more prudent than telephone advice*';
    - maternal fever should have been viewed as a risk to G and the fact that it was not was a missed opportunity to identify his illness;
    - the fact that G required three-hourly observations and was not maintaining his temperature should have prompted a paediatric review;
    - it had not been possible to find the observation chart, which had gone missing; and
    - '*the high activity and shift changes at critical points may have contributed to the lack of a considered assessment of this case*' in relation to whether staffing levels were adequate at the time.

The Trust's actions following Mr D's complaint

34. On 15 November 2008 Mr D made a complaint to the Trust about the care and treatment provided for his son and his wife.

35. In order to respond to Mr D's complaint, the Trust commissioned an external review of the care provided for G. This review was carried out by the head of midwifery at Macclesfield District General Hospital (managed by East Cheshire NHS Trust), a consultant obstetrician and gynaecologist and a consultant paediatrician, both from the Royal Albert Edward Infirmary Wigan (managed by Wrightington, Wigan and Leigh NHS Foundation Trust).

36. The authors of the report met Mr D and his family in December 2008. During this meeting Mr D said that he wanted '*an acknowledgement that* [G's] *temperature had been low and recognition that he a*nd [Mrs D] *had expressed their concern about this*'. The reviewers said that this had been acknowledged by the Trust and that it was '*validated by comments made in staff statements*'. Mr D also described G's condition at birth (namely, that he did not cry, was limp and looked blue) and the fact that he constantly failed to maintain his temperature. Mrs D explained that she recalled knocking over the observation chart and seeing two entries that reflected G's temperatures of 35.8°C and 36.1°C, and

that this was the reason that they were both so concerned about the missing observation chart. The reviewers said that they accepted Mr and Mrs D's version of the care provided for G, and his condition.

37. The external report was produced in February 2009. The report was based on the recollection of the family, Mrs D's and G's records (insofar as these were available), the root cause analysis carried out by the Trust and the staff statements. The authors of the report did not interview or re-interview any of the staff involved in Mrs D's or G's care.

38. The report said that, following the spontaneous rupture of her membranes, Mrs D was managed in line with recognised accepted practice. However, swabs to check for infection were not taken from G. This was contrary to Trust guidelines, which said that a swab should be done when membranes have been ruptured for more than 24 hours. The report said that there was no evidence that a standard baby check had been carried out by a midwife when G was born.[12]

39. The report said that there was no evidence of a holistic overview of care, which would have included consideration of the potential consequences for G of the maternal infection. The report also said that there was no evidence of a handover of care for Mrs D and G when they were transferred from the labour ward to the postnatal ward, and that it appeared that '*workload pressures*' may have influenced the care that was provided. The report also identified that there appeared to be a lack of staff awareness that persistent hypothermia[13] in a neonate can be a sign of sepsis[14] and that Trust staff had failed to recognise the relevance of neonatal hypothermia and the need to refer G for a medical assessment. The report concluded that if antibiotics had been given to G earlier, he might have survived. The report also said that record keeping following G's birth was of an exceptionally poor standard.

40. The report set out seven key recommendations, which were then incorporated into a 17-point action plan. To improve services the Trust should:

    1) review and clarify their policies for the management of pre-labour rupture of membranes;

    2) review the management of premature newborn infants with prolonged spontaneous rupture of membranes and potential sepsis;

    3) produce a written policy with regard to the calculation of gestation from ultrasound scans, based on current guidance;

    4) review and enhance their policies for the monitoring and care of neonates, including clear indications for medical review by a neonatal paediatrician and identification of trigger factors;

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12 A later investigation by the Local Supervisory Authority took issue with this finding, and said that an electronic audit demonstrated that the initial baby check had been carried out, including weight, size and so on.

13 Mild hypothermia in newborns is defined as a core body temperature of 36°C to 36.4°C, moderate hypothermia as 35.9°C to 32°C and severe hypothermia as less than 32°C [Department of Reproductive Health and Research (RHR), World Health Organisation]. *Thermal protection of the newborn: A practical guide* (WHO/RHT/MSM/97.2). Geneva: World Health Organisation. 1997.

14 Sepsis is a life-threatening illness that is caused by the body overreacting to an infection.

5) provide training to staff in relation to neonatal care and observations, and in identifying signs of sepsis;

6) provide information to staff on the management of neonates not maintaining their temperature;

7) improve the standard of record keeping by midwives for neonates;

8) be clear who the named carer is at all times, and ensure that effective handover of care is carried out, with better documentation;

9) the temperature in the rooms in which neonates are nursed should be monitored on a continuous basis;

10) review midwifery staffing in relation to caseload to ensure appropriate staffing levels;

11) seek external advice about ethnic minority women[15] and any possible increase in neonatal infection risks;

12) review the response of paediatricians to midwife referrals to ensure this is appropriate and timely;

13) share with staff the policies and guidelines for obstetrics and maternity services and paediatrics;

14) speak to the paediatrician who failed to respond to midwives' bleep calls on 27 October 2008;

15) ensure that there are regular perinatal meetings at the Hospital;

16) arrange a debrief about what happened to G with relevant staff; and

17) review all critical infrastructure risk for a six-month period in the maternity unit at the Hospital from September 2008 to March 2009, and report on common themes and actions.

41. The report was shared with Mr D and his family during a meeting at the Hospital on 9 February 2009. Four days later, Mr D gave the Trust his preliminary written comments on the report.

42. Mr D said that the report was of poor quality because it had numerous typographical and grammatical errors, and sentences that appeared to be cut short. He asked the Trust whether the report they had provided was the full report, and the only one available, or whether there was a more comprehensive version that had not been shared with him and his wife. He also asked whether the consultant paediatrician (one of the three external reviewers) had provided a fuller and more detailed contribution. On 20 February 2009 Mr D wrote to his MP setting out some of the concerns that the Trust's external report had identified. (These are detailed below.)

43. In March 2009 Mr D met the chief executive of the Trust. They agreed that the Trust would write to Mr D and '*concentrate on answering the outstanding issues that* [were] *clearly outlined*' in Mr D's letter to his MP.

44. On 25 March 2009 the Trust wrote to Mr D and acknowledged the external report's fundamental conclusion, which was that '*the care received by* [G] *was not acceptable*' and that '*as a direct consequence, he lost his fight for life*'.

15 Mrs D is of Vietnamese origin.

The Trust then proceeded to address the concerns that Mr D had raised with his MP:

- swabs were not taken from G – the Trust said that when Mrs D became ill, this should have triggered a review of G's condition, including taking a swab from him. They said that they would carry out a review of the policy for pre-labour rupture of membranes. They said that this would include a review of when active management following pre-labour rupture of membranes should begin;
- no standard baby check was carried out on G – the Trust said that there was no record in the notes that the initial baby check was carried out. However, they said that G's APGAR scores were recorded and a midwife confirmed that a check was carried out before G was transferred to the maternity ward. The Trust acknowledged that this issue was part of the unacceptable standard of record keeping;
- no holistic overview of care and monitoring of G – the Trust said that they would be reviewing the policies that supported the safe care of neonates, including reviewing the trigger points for infection. They said that the maternity risk management group, together with the clinical leads for obstetrics, paediatrics and midwifery, were ensuring that these policies were being adhered to;
- no examination by a paediatrician – one midwife said that she had contacted the paediatrician on call, who gave an instruction to observe G. However, there were two paediatricians on call, neither of whom had any recollection of that conversation, and they were due to be formally interviewed. The Trust also confirmed that G's estimated likelihood of survival, if antibiotics had been started at the same time as Mrs D's were, would have been around 90%;
- no handover of care to the postnatal ward;
- workload pressures contributed to the inadequate care provided – the Trust explained that they had a policy in place to deal with fluctuating workloads, and this included a '*floating*' midwife who was allocated to any area where the workload was high, as it was when Mrs D became ill. The Trust acknowledged that there was no handover of G's care from the labour ward to the postnatal ward and said that this was unacceptable. However, they said that while the external report did make a reference to '*workload pressures*' potentially having an impact on G's care, they did not accept that staffing levels at the time failed to meet the minimum safe staffing levels. Nonetheless, the Trust said that they would be reviewing staffing levels and that written care plans would be changed to ensure that appropriate handovers took place and were documented;
- ignorance of staff of the relevance of hypothermia – the midwives should have recognised that a low temperature, or a failure to maintain a temperature, was a sign of infection. They said that this was a clear failing by management and that further training about the recognition of neonatal sepsis and neonatal care had been arranged; and
- inadequate record keeping – the standard of record keeping was below an acceptable standard. They said that the clinical audit department would be auditing record keeping and

any shortcomings identified would be dealt with appropriately. They raised particular concerns about two midwives, but said both had been referred for midwifery supervision.

45. The Trust acknowledged the external report's concerns about the appropriateness of the management systems that supported the delivery of midwifery care at the Hospital and said that an external management consultant would review the overall management of the maternity services.

46. Following this response, there were several further exchanges between Mr D and the Trust, and on 9 April 2009 Mr D asked to see the statements provided by staff under the *Freedom of Information Act 2000* (the FOI Act). The Trust refused to allow this. On 14 April 2009 the Trust sought advice from their legal department which said that, while the FOI Act did not apply to this request, the *Data Protection Act 1998* (the Act) would and, in particular, that '*given that the investigation for which the statements were obtained is now complete and* [Mr D] *has a copy of the report, there are no grounds to withhold the substance of the statements under this Act*'. The advice also said that '*refusing to disclose them immediately* [would] *only create suspicion and ill will*'. The chief executive of the Trust, however, responded by saying that he did not want to release the statements because it was not '*in the spirit*' of the way he had been trying to address Mr D's complaint.

47. The Trust eventually disclosed to Mr D the statements taken for the purposes of the root cause analysis on 15 July 2009. The Trust have told us that no further statements were taken from staff involved in Mrs D's and G's care. They said that further unsigned versions of the statements taken for the purposes of the root cause analysis were prepared for the purposes of disclosure to the NMC. These unsigned versions effectively transferred the content of the original statements on to a statement template suitable for disclosure to the NMC as part of the NMC's regulatory process.

Subsequent reports

The Local Supervisory Authority's report

48. On 22 May 2009 the Local Supervisory Authority[16] produced a report about the midwifery care provided for Mrs D and G. It concluded that midwives had missed potential opportunities for intervention, although they said that the changes in G's condition were subtle, in particular, that his temperature fluctuated within normal limits. The Local Supervisory Authority said that it was impossible to say whether these interventions would have altered the outcome. (This is in contrast to the Trust's assessment that G would have had a 90% chance of survival, had he received antibiotics earlier.) The Local Supervisory Authority agreed that there were concerns about the standard of record keeping at the Trust. However, they concluded that, whilst the care given to Mrs D and G was not recorded to a satisfactory standard, the care itself was of a satisfactory standard. They made recommendations (about retraining) for four of the midwives involved in G's care and they said that staffing levels at the maternity unit were appropriate.

16 The Local Supervisory Authority is a statutory function designed to regulate the individual practice of midwives. At the time of the events in question, this function was discharged by the relevant strategic health authority (SHA), in this case NHS North West.

49. Following a separate complaint that Mr D made about this report, one of the midwives was interviewed again and accepted that Mrs D's recollections of G's temperatures were probably accurate.

Implementation of the action plan

50. In June 2009 the Trust, in co-operation with NHS Audit North West,[17] reviewed their progress against the 17-point action plan. The report concluded that progress had been made on each of the action points, but acknowledged that some actions needed further work.

The Fielding report

51. In March 2010 another external report was commissioned by the Trust (the Fielding report). This report referred to Mr D's case (and other incidents). It was a much broader review of the Trust's maternity services, both at the Hospital and at other locations managed by the Trust. The report concluded that the Trust had made considerable progress in addressing the issues that had been identified as a result of what the report called a '*cluster of incidents*' (which included the management of G). However, it highlighted a number of issues that had not been addressed, and it made recommendations for further action. The following recommendations were particularly relevant to this complaint:

    a) all clinical practice issues highlighted as a result of previous investigations should continue to be part of an ongoing audit programme;

    b) management and supervisors of midwives must agree criteria for dealing with staff after incidents;

    c) consideration should be given to ensuring that an appropriate paediatrician in each of the two specialist units managed by the Trust should have dedicated sessions for the neonatal units;

    d) the Trust should consider how to co-ordinate and formalise systems for measuring the quality of patient experience in maternity services;

    e) multidisciplinary ward rounds should be introduced as a matter of priority on labour wards, to provide the opportunity for discussion about what has happened overnight, what activity is expected during the day, whether the right staff are available and what can be done if they are not; and

    f) training opportunities for midwives should be reviewed with a view to ensuring appropriate professional development.

    This report was not disclosed to Monitor in 2010 when the Trust was granted foundation trust status, and was not made public until 2011.

52. In 2011 NHS Audit North West was commissioned by the Trust to '*undertake a review of its response to* [the Fielding report] *and to provide a position statement as to the extent to which actions undertaken can be evidenced*'. The objective of the audit was to '*test the strength of the Trust's evidence of compliance with the recommendations of the Fielding report as at May 2011 and to provide an assurance level at that point in time*'.

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17 NHS Audit North West is a specialist NHS assurance provider that provides auditing and anti-fraud services to a variety of NHS organisations.

53. This report concluded that the Trust had '*produced sufficient evidence to fully or substantially support implementation of a majority of the thirty-six recommendations in the Fielding report*', although work was in progress in some instances. In terms of the recommendations set out at paragraph 51 of this report, four were judged to be '*complete*' (a, b, d and f) while two were either ongoing or partially complete (c and e).

Findings

54. In determining whether the Trust adequately investigated the events surrounding G's death, I refer to the Ombudsman's Principles (paragraphs 9 and 10). In order to 'act fairly and proportionately', the Trust should have investigated the events surrounding G's death thoroughly and fairly to establish the facts. This should have included reviewing G and Mrs D's records, identifying the care that should have been provided for them, and establishing whether this care was actually given. In the absence of records, the investigation should have included detailed statements from members of staff involved in providing care, ensuring that any gaps in the records were appropriately addressed. When responding to Mr D's complaint, the Trust should have been 'open and accountable' by providing clear, evidence-based explanations and reasons for their decisions. They should also have apologised for any failings in care, and set out the actions they intended to take to ensure that any failings identified would not happen again.

The root cause analysis

55. The Trust carried out a root cause analysis between November 2008 and January 2009, which included interviewing members of staff and taking statements from them. Most of the statements were taken during the first week of December 2008. The statements were important in establishing a chronology of the care provided for G, because crucial records, including a chart detailing regular observations by midwives, were missing.

56. The maternity risk manager who collated the statements for the purposes of the root cause analysis should have ensured

that the statements were comprehensive, detailed and consistent. In fact, some of the most important statements lacked detail. For example, one of the statements recalled G's temperatures being '*low*' but no further information was provided, or apparently asked for, as to what '*low*' meant in this context. Another statement said that, if after G had been moved again to a warming cot, he still could not maintain his temperature, a paediatrician would need to review him. There was no explanation for why this midwife did not feel an immediate review was necessary, given that observations had already shown that G was not maintaining his temperature.

57. In addition, not only did the maternity risk manager not challenge the statements when they were vague, she also did not challenge them when they were inconsistent. For example, some of the midwives recalled the observations were being done every three or four hours, while the consultant paediatrician who treated G after he was found collapsed, recalled in his statement that the midwife had explained to G's parents that '[G's] *circumstances had been explained and advice was given to monitor every hour*'. Given that there was no record of a conversation between the midwife and the paediatrician, this was an inconsistency that needed to be resolved.

58. What the root cause analysis did, however, was identify what went wrong during G's care and particularly that '[G's] *inability to maintain his temperature had not been recognised as a potential sign of sepsis*'. In addition, the root cause analysis concluded that there should have been '*a review of the baby*' by a paediatrician, rather than just a telephone conversation, when Mrs D was found to be very ill immediately after G's birth. It also identified '*many missed opportunities for intervention*', including the initial missed paediatric review, and a further missed review when G was transferred to a warming cot for a second time because he was not maintaining his temperature. These were appropriate conclusions about the failings in care and treatment of G.

59. However, the conclusion that, despite these '*missed opportunities*', it was '*impossible*' to say whether those interventions would have altered the outcome, is not supported by a logical assessment in the root cause analysis report. As later confirmed by the Trust, G would have had an excellent chance of survival if opportunities to treat and diagnose his infection had not been missed.

The external report commissioned by the Trust

60. Following the root cause analysis, the Trust commissioned an external review. The external reviewers met Mr D and his family on 31 December 2008, when the family's recollections of G's birth and postnatal care were discussed.

61. In many important respects, their recollections differed from the statements provided by the midwives, and this should have alerted the external reviewers to the potential need to re-interview some members of staff. Mr and Mrs D said that G did not cry at birth and that he '*appeared blue and limp*'. This was very different from what the midwives had said in their statements. They said G had '*cried immediately*' after being born and was given an APGAR score of nine, with a point having been deducted because of blue '*extremities*'. There were also differences in Mr and Mrs D's recollection of G's temperature fluctuations after his birth.

62. Mr D had said that he wanted '*an acknowledgment that* [G's] *temperature had been low and recognition that he and* [Mrs D] *had expressed their concern about this*'. At the meeting, they were told that this had been acknowledged by the Trust and '*validated by comments, made in staff statements*'. However, I have seen no evidence that this was the case. Only one of the midwives (of the nine who provided statements) said that G's temperature was '*low*'. A second midwife said that, following observations which were '*within normal limits*' in the early hours of 28 October 2008, a later set of observations had identified that G's temperature had dropped by 0.2 or 0.3 degrees. Mrs D recalled seeing the observation chart and that G's temperature had dropped to 35.8°C and 36.1°C, but this was not mentioned by any of the midwives. In addition, none of the midwives recalled Mr and Mrs D raising concerns about G's temperatures. It was therefore not appropriate for them to be told that their version of events was validated by staff statements, when it clearly was not.

63. The external reviewers told Mr and Mrs D that they accepted their version of events and, on that basis, re-interviewing staff may have seemed unnecessary. However, it was clearly important to try to resolve any discrepancies, particularly in the absence of clinical records. Re-interviewing the midwives would have made the midwives aware of Mr and Mrs D's version of events, and provided them with an opportunity to try to recall further information and/or to agree with the family. In fact, in June 2009, following the Local Supervisory Authority report, one of the midwives accepted Mrs D's recollection of G's temperatures. If the external reviewers had done this in December, this agreement could have been reached much sooner. The fact that the external reviewers did not re-interview any of the staff was a failing.

64. However, the report provided an evidence-based explanation of the failings in the care provided for G. It identified the fact that swabs were not taken from G, despite the Trust's guidelines being clear that this should have been done, and that there was no holistic overview of care following G's birth. It also appropriately concluded that there appeared to be a lack of staff awareness that persistent hypothermia in a neonate can be a sign of sepsis, and that this would require medical assessment. The report said that at the time, it would have been accepted practice for a paediatrician to have examined G, given his mother's history of prolonged rupture of membranes, and this did not happen. It identified that staff did not refer G for a medical assessment when they should have done, and that the record keeping was exceptionally poor. In addition, the report said that it appeared to the authors that workload pressures may have influenced the care provided. Whilst the presentation of the report is undoubtedly careless (there are numerous typographical errors and grammatical mistakes, and some incomplete sentences), it fully acknowledges and identifies the failings in G's care.

The Trust's letter to Mr D

65. Following a meeting with Mr D to discuss this report, the Trust wrote to Mr D on 25 March 2009 to respond to the concerns he had raised with his MP. This letter '*formally*' recognised that '*the care received by* [G] *was not acceptable*' and that, '*as a direct consequence, he lost his fight for life*' and apologised for this.

66. In this letter, the Trust acknowledged that swabs were not taken from G, and that at the very least this should have been done when Mrs D became ill after his birth. The Trust set out the actions they would be taking to address Mr D's concerns, for example, by reviewing the policies about pre-labour rupture of membranes, including the management of babies. They also said that both doctors on call that day would be formally interviewed by the medical director.[18] The Trust said that G's chances of survival, if he had been given antibiotics at the same time as they were given to Mrs D, would have been about 90%. They set out the further training that would be given to midwives and their plans to audit the record keeping to address the unacceptable standard of record keeping seen in Mrs D's and G's medical records. They confirmed that two of the midwives involved had been referred to the Local Supervisory Authority. The Trust, however, did not accept that there were inadequate staffing levels at the time, although they said that the head of midwifery would undertake a review of the staffing levels.

67. Finally, the Trust also said that the external report had raised concerns about the management system that supported the delivery of midwifery care. An external management consultant had therefore been asked to carry out a review of the overall management of the maternity service.

68. Each concern which Mr D had raised with his MP, and which the Trust agreed to respond to, was addressed, in addition to the failings already clearly identified in the external report, and reiterated at the start of the Trust's letter. The Trust, having acknowledged the failings, addressed Mr D's ongoing concerns as agreed.

The Trust's refusal to disclose the statements from staff

69. Whilst it is not our role to determine whether there has been a breach of the Act, the guidance provided by the Information Commissioner says that even if a request does not mention the Act, it should still be considered as such a request, if it is clear that the request is about the person's own data. In this case, the Trust realised that the request Mr D was making could come under the Act and would have to be disclosed. They should have dealt with his request promptly and within the 40 calendar day period allowed in the Act.

70. There was no reason not to disclose the statements. The Trust had, by this stage, accepted the family's account of events and all the failings in G's care. The Trust's failure to disclose the information was neither in line with the applicable guidance, nor was it 'open and accountable'.

71. In relation to these statements, Mr D has raised an additional concern in that he has told us that further, more comprehensive, statements were produced by staff, and later destroyed. I have seen no evidence that this is the case, and the Trust have told me that no further statements were prepared.

Overall conclusions

72. I have found that the initial root cause analysis identified the most important failings, and the subsequent external

18 At this formal interview, neither doctor admitted taking the call, and there was no way to actually prove which doctor had responded. Therefore, a decision was made to place warning letters on each doctor's file on the basis that one of them must have received the call.

report supported these findings and expanded on them. Mr D has complained that the report was not independent, but the report was produced by three senior professionals from different NHS organisations. Whatever their personal relationship with the chief executive of the Trust, I have seen no evidence that the report approached the events that led to G's tragic death in anything other than an unbiased and critical way. I have found that the external reviewers' decision to speak to Mr D and his family was appropriate, and the Trust's subsequent letter to Mr D responded to his concerns and explained what the Trust would do to ensure that these concerns were addressed.

73. Nonetheless, I have also found that there were serious deficiencies in this process. The statements originally taken from staff were neither detailed enough, nor challenged as part of the root cause analysis process. I have found that the external reviewers should have interviewed or re-interviewed staff when they were alerted to the significant differences between Mr and Mrs D's recollections of G's birth and postnatal care, but they did not. Whilst it might have ultimately been impossible to do, I have found that not enough was done to try to resolve these discrepancies at an early stage. I have also found that the Trust inappropriately refused to disclose the statements that had been provided by staff, even though they knew that these were subject to the provisions on disclosure in the Act.

74. Having considered all the evidence, I find that the failings I have identified were serious because the Trust had a responsibility to ensure that the circumstances of baby G's death were thoroughly investigated. The Trust had already acknowledged failures in G's care and that these failings led to his death. The original failures of care were compounded by the failure to investigate properly and to answer all of Mr D's very legitimate concerns. I therefore find that the failings I have identified amount to maladministration.

Injustice

75. Having found maladministration in the way the Trust investigated the events surrounding G's death, I now consider the impact of that maladministration on Mr D.

76. Mr D has said that these actions by the Trust compounded his distress at a very difficult time. It is clear that, right from the very start, the loss of G's observation chart was very distressing for Mr D. This was the only document that set out objectively what he saw as the clear signs that his son was ill and required care. Without it, Mr D was relying on staff to acknowledge that they had failed to provide appropriate care to G. In addition, he was relying on staff to recall, in detail, the care that they provided. It is quite clear, therefore, that any failure to ensure that these statements were detailed, comprehensive and consistent would considerably hamper the chances of establishing exactly what care was provided for G.

77. The distress Mr D had suffered was exacerbated by the external reviewers' failure to put to staff Mr and Mrs D's account of what had happened. After being told that his account was validated by staff statements, Mr D was eventually confronted with statements that provided a very different account of G's birth and subsequent care. By this stage, nine months had passed since G's time at the Hospital, and it was therefore almost impossible to address any discrepancies. I can understand that this would have been very distressing for Mr D. All of this was an injustice to him that arose from the maladministration identified in this report.

78. In the circumstances, I can understand why Mr D has lost all confidence that the Trust will learn lessons from his son's tragic death. A year after the Trust's response to his complaint, the Trust had not disclosed the contents of an external report on their maternity services to the relevant regulator or to the public. I can understand why this would have further convinced Mr D that the Trust were not committed to learning from the tragic circumstances surrounding the care provided for G while at the Hospital. The further erosion of Mr D's confidence in the Trust is another injustice flowing from the Trust's maladministration.

Recommendations

79. I have considered my findings in the light of the Ombudsman's Principles for Remedy. Two of these Principles are particularly relevant here:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation or remedial action); and
    - '*Seeking continuous improvement*' – which includes using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated.

80. I recommend that the Trust should, within one month of the date of the final report:

    - provide Mr D with an acknowledgement of the failings identified in this report and an apology for the consequential injustice;

    and, within three months of the date of this final report, should prepare an action plan that:

    - describes what the Trust have done to ensure that the organisation has learnt lessons from the failings identified by this upheld complaint; and
    - details what they have done and/or plan to do, including timescales, to avoid a recurrence of these failings.

81. A copy of the action plan should be sent to:

    - Mr D
    - us
    - the Care Quality Commission (CQC)
    - Monitor, and
    - NHS Cumbria Clinical Commissioning Group.

82. The Trust should also ensure that Mr D, the CQC, Monitor and the clinical commissioning group are updated regularly on progress against the action plan.

83. A copy of the apology letter should be sent to us.

The Trust's and Mr D's response to the draft report

84. In response to a draft of this report, the Trust acknowledged and accepted our findings and recommendations.

85. Mr D also accepted our findings and recommendations when we shared the draft report with him.

Conclusion

86. In this report, I have set out our investigation, findings and conclusions and decision with regard to the way in which the Trust investigated the events surrounding G's death. I have found maladministration and concluded that an injustice arose to Mr D in consequence of this maladministration. I therefore uphold the complaint about the Trust.

Complaint about an offensive email

Contents

Introduction

1. This is the final report of the investigation into Mr D's complaint about University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust). This report contains my findings, conclusions and recommendations.[1]

The complaint

2. Mr D has serious concerns relating to an incident that took place on 10 August 2009, in which an email, titled '*NMC shit*', was sent by a Trust midwife. The email was sent in connection to a Nursing and Midwifery Council (NMC)[2] investigation into the midwives' actions surrounding the death of Mr D's baby son, G.

3. We have investigated Mr D's complaint that the Trust failed to tell him about the exact nature of the email from the Trust on 10 August 2009, and that the Trust were not open and accountable in their response to his complaint about the email incident.

4. Mr D says that this episode has added to the distress and upset he is experiencing with regard to his concerns over the care his son received from the Trust. Mr D says that he would like the Trust to acknowledge that (a) he was not fully informed of the incident at the time and that he should have been; (b) the NMC were not made aware of the incident at the time (and the Trust should offer either an apology for this or an explanation as to why not); (c) that a Trust press statement, which implied that Mr D was made aware of the incident at the time, was misleading; and (d) this incident was not dealt with openly and honestly.

5. Mr D would like an apology from the midwives involved with the email and an assurance from the Trust that systems are now in place to deal with situations like this openly and honestly. He would also like an assurance from the Trust that they are not aware of any other similar matters which they have not informed him of.

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1 Since we issued this report, we have changed some of the wording we use. This might account for some minor differences or inconsistencies between the four reports.

2 The Nursing and Midwifery Council regulates nurses and midwives in England, Wales, Scotland, Northern Ireland and the Islands.

The decision

6. Having considered all the available evidence related to Mr D's complaint about the Trust, I have reached a decision.

7. I have found maladministration in the Trust's failure to tell Mr D about the exact nature of the email sent on 10 August 2009. I have found maladministration in the Trust's handling of Mr D's complaint about the email incident. The identified maladministration has caused Mr D the injustice of distress.

8. I therefore uphold Mr D's complaint about the Trust.

9. In this report I explain the detailed reasons for my decision and comment on the particular areas where Mr D has expressed concerns to the Health Service Ombudsman.

The Ombudsman's jurisdiction and role

10. By virtue of the *Health Service Commissioners Act 1993*, the Ombudsman is empowered to investigate complaints about the NHS in England. In the exercise of her wide discretion she may investigate complaints about NHS bodies such as trusts, family health service providers such as GPs, and independent persons (individuals or bodies) providing a service on behalf of the NHS.

11. In doing so she considers whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the body, a failure by the body to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the body. Service failure or maladministration may arise from action of the body itself, a person employed by or acting on behalf of the body, or a person to whom the body has delegated any functions.

12. If the Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with the Principles for Remedy, she may recommend redress to remedy any injustice she has found.

The basis for my determination of the complaint

13. In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, we generally begin by comparing what actually happened with what should have happened.

14. So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those bodies and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

15. The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

16. Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the body or individual complained about constitutes a departure from the applicable standard.

17. If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

18. The overall standard I have applied to this investigation is set out below.

The general standard – the Ombudsman's Principles

19. In February 2009 the Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy were republished.[3] These are broad statements of what the Ombudsman considers public bodies should do to deliver good administration and customer service, and how to respond when things go wrong. The six key Principles are:

    - Getting it right
    - Being customer focused
    - Being open and accountable
    - Acting fairly and proportionately
    - Putting things right, and
    - Seeking continuous improvement.

20. The Principle of Good Administration particularly relevant to this complaint is:

    - '*Being open and accountable*' – this includes public bodies giving people information that is clear, accurate, complete, relevant and timely.

21. The Principle of Good Complaint Handling particularly relevant to this complaint is:

    - '*Being open and accountable*' – this includes public bodies being open and honest when accounting for their decisions and actions.

3 The Ombudsman's Principles is available at www.ombudsman.org.uk.

The investigation

22. We discussed with Mr D the nature of his complaint and how our investigation would proceed on 5 December 2011. We confirmed our understanding of the complaint in our letter of 21 December.

23. During this investigation, we have considered relevant documents about Mr D's complaint, including documents relating to the attempts to resolve the complaint at local level.

24. In this report I have not referred to all the information examined in the course of the investigation, but I am satisfied that nothing significant to the complaint or my findings has been omitted.

Key events

25. Midwives from the Trust were under investigation by the NMC in relation to their conduct and practice surrounding the sad death of Mr D's baby son, G, in August 2009. An email that contained the draft responses of a midwife to the NMC's questions surrounding G's death was sent from a Trust computer on 10 August 2009. It appears that the midwife asked a colleague to forward a copy of the email from the midwife's work account to the personal email address of her husband so that she could work on this at home. The colleague accessed the midwife's NHS email account but appears to have sent the email to an incorrect email address. This was identified by the midwife when she did not receive the email within two hours. A serious untoward incident report was requested and established by the Trust.

26. The Trust's medical director contacted Mr D on 13 August 2009 to confirm that an email had been sent to an incorrect address and that the email had contained personal information about the D family. Mr D followed this up with the Trust and requested a copy or summary of the email to assure him that nothing in the email would cause any undue concern to the family.

27. The medical director wrote to Mr D on 2 September 2009. He confirmed that the email related to the ongoing NMC investigation into G's care and contained the allegations made by the NMC and the midwife's draft responses. The medical director said that the document referred to the D family by name, but contained no further personal information. He confirmed that the matter had been reported to the Information Commissioner and that a serious untoward incident report was

ongoing. He said that a senior colleague had assured him that the email was a '*comprehensive, professional account of the midwife's recollection of events*' and that the Trust believed the email had been sent to a dormant account that had not been accessed by any member of the public.

28. Mr D subsequently requested a copy of the serious untoward incident report under a freedom of information request in December 2010. Mr D was sent an electronic copy of the email on 7 January 2011. It appears that he was able to remove the electronic redaction on the serious untoward incident report and found that the subject heading of the email in question was '*NMC shit*'.

Local resolution

29. Mr D subsequently notified the NMC about this incident and made a complaint to the Trust on 10 January 2011. These concerns appeared to relate to data protection issues, but he noted the concern that the email had been entitled '*NMC shit*' at this time.

30. The Trust's chief executive responded to Mr D via email on 11 January 2011. He said that he was '*personally disgusted*' and that such behaviour was not condoned. He explained that the title of the email had not been disclosed at the time as it was felt that not all the information was required to be disclosed under the *Freedom of Information Act*. The chief executive's further written response on 25 January explained the background to the freedom of information request and confirmed that the midwives had been investigated under the Trust disciplinary policy. The letter apologised for any additional distress the disclosure caused and hoped that Mr D was assured that necessary action had been taken.

31. The matter came to the attention of the media and the Trust issued a press release on 22 July 2011. The Trust commented that the chief executive had written to Mr D at the time to apologise for the distress caused to their family and that the NMC had been notified of the incident. Mr D made another freedom of information request in August. He discovered that the Trust had not originally notified the NMC of this incident and had only done so once Mr D had raised his concerns with the Trust. Mr D subsequently emailed the Trust on 23 August to ask why a referral had not been made at the time; what had led to the Trust notifying the NMC; and if this notification was purely down to Mr D becoming aware of the nature of the email's title. Mr D also raised concerns about the accuracy of the press release issued by the Trust.

32. The Trust's response was issued by their solicitors on 9 September 2011. The Trust believed that it was appropriate to deal with the email incident as an internal disciplinary matter. It was not considered to be a regulatory matter such as to lead to a notification to the NMC. The Trust said that they did not report all internal disciplinary matters to the regulatory bodies. Information was provided to the NMC, however, following Mr D's notification to the NMC in January 2011. Given this, the Trust said that the press statement was correct in saying that the NMC were notified. The Trust accepted that it was the medical director who originally wrote to Mr D, with the chief executive later apologising on 25 January 2011. The Trust reiterated their previous apologies but said that they had nothing further to add on the matter.

33. Correspondence between Mr D and the Trust continued intermittently before and after Mr D contacted the Ombudsman with his complaint on 14 September 2011.

34. In Mr D's email to the Trust on 13 October 2011, he said that it was quite clear that the Trust had no intention of informing the NMC about the email incident '*as evidenced by the fact that when I* [Mr D] *contacted them in January 2011 they knew nothing of the incident at all*'. In a further email to the Trust on 14 October, Mr D said that the Trust did not inform him about the email incident at the time and that they were fully aware that the key facts of the matter were hidden from him. He said that but for his '*accidental disclosure*' the Trust would have had no intention of informing the NMC. In their reply of 18 October, the Trust's solicitors said that the Trust had already provided an explanation as to their handling of the incident and did not want to enter into further protracted correspondence now that the matter had been referred to this Office.

Findings

35. In determining whether there has been service failure or maladministration, I refer to the Principles of Good Administration. In particular, I have assessed against the Principle of '*Being open and accountable*' – that is, public organisations giving people information that is clear, accurate, complete, relevant and timely. I have also assessed against the Principle of Good Complaint Handling, in particular, the Principle of '*Being open and accountable*' – that is, public organisations being open and honest when accounting for their decisions and actions.

36. Mr D was notified by the Trust within three days that an email containing personal information about his family had been sent to an incorrect address. In doing so, the Trust acted in an 'open and accountable' manner.

37. The Trust followed up their initial contact with a letter to Mr D on 2 September 2009. The letter was sent by the medical director. This letter said that the email in question was a '*comprehensive and professional account of the midwife's recollection of events*' concerning his son's care. This cannot be said to be true as the email was titled '*NMC shit*'. Given the email's offensive title, Mr D was misinformed by the Trust when they stated that the email was a '*professional account*'. Although we can understand the Trust's inclination to spare Mr D further anguish by not disclosing the title of the email, they were not 'open and accountable' in their response.

38. In their press release of 22 July 2011 the Trust said that the chief executive had written to Mr D around the time of the email incident to apologise. The press release also said that the NMC had been

informed about the incident. As later acknowledged by the Trust, the chief executive did not write to Mr D and apologise at the time of the incident. The chief executive did not do so until January 2011, nearly 17 months after the email had been sent and was found to have gone astray. The Trust were not 'open and accountable' in saying that the chief executive had apologised to Mr D at the time of the incident.

39. Mr D has apparently inferred from the press release that the Trust informed the NMC at the time the email incident was reported. The Trust have said their statement that the NMC had been notified was correct, coming as it did after Mr D had informed the NMC in January 2011. It is clear that the Trust and Mr D have interpreted this part of the press release in a different way. As the Trust did not explicitly say that they had notified the NMC at the time of the email incident, I am unable to say with any certainty that their actions in this regard were contrary to the Principle of '*Being open and accountable*'. The Trust, however, have not answered Mr D's question as to why they did not notify the NMC about the email incident until after Mr D had contacted the NMC. Although it was reasonable for the Trust to say that they do not routinely refer all disciplinary matters to the NMC, this does not address Mr D's concerns as to why they subsequently decided to do so. The Trust have not been 'open and accountable' in this regard.

40. When looked at in the round, the Trust have not acted in a manner that can be described as appropriately 'open and accountable'. They misinformed Mr D as to the exact nature of the email and issued a press release which incorrectly stated that the chief executive had apologised to Mr D at the time of the incident. The Trust have not addressed all of Mr D's concerns, particularly that of why they decided to refer the matter to the NMC. I find that, in view of these shortcomings, both the Trust's initial response to the email incident and the Trust's subsequent handling of Mr D's complaint fell so far below the applicable standard as to amount to maladministration.

Injustice

41. I now consider whether the maladministration I have identified led to an injustice to Mr D.

42. Mr D says that this episode has added to the distress and upset he is experiencing with regard to his concerns over the care his son received from the Trust.

43. I have found maladministration in the Trust's failure to tell Mr D about the exact nature of the email sent on 10 August 2009. I have found maladministration in the Trust's handling of Mr D's complaint about the email incident. I note that the Trust have apologised for the distress caused by the disclosure of the email and that they have acknowledged that aspects of their press release in July 2011 were incorrect. It remains, however, that the Trust's actions since Mr D was informed of the email's disclosure has unnecessarily, and unjustifiably, caused him further distress.

44. Even with the benefit of hindsight, all of the identified shortcomings were eminently avoidable and have served to worsen a situation caused by the inexplicable sending of an insensitively titled email. It has without question further undermined Mr D's confidence in the Trust. Indeed, Mr D remains concerned that there are other matters with the Trust concerning him and his family that he may as yet be unaware of. This is the injustice to Mr D.

Final remarks

45. I have found maladministration in the Trust's failure to tell Mr D about the exact nature of the email sent on 10 August 2009. I have found maladministration in the Trust's handling of Mr D's complaint about the email incident. The identified maladministration has caused Mr D the injustice of distress.

46. I therefore uphold the complaint about the Trust.

Recommendations

47. I have considered my findings in the light of the Ombudsman's Principles for Remedy. Two of these Principles are particularly relevant here:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation or remedial action); and
    - '*Seeking continuous improvement*' – which includes using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated.

48. I have already asked the Trust to prepare an action plan to remedy the poor complaint handling we have identified in a number of cases involving the Trust. In addition I have recommended an individual remedy for Mr D. I therefore recommend that the Trust should:

    (a) within one month of the date of this final report, write to Mr D to acknowledge the maladministration and apologise for the injustice I have identified. A copy of their letter should be sent to the Ombudsman;

    (b) within one month of the date of this final report, respond in full to Mr D's outstanding concerns regarding the Trust's original description of the email as a professional account and their decision to report the matter to the NMC; a copy of their response should be sent to the Ombudsman.

    (c) within three months of the date of this report, offer financial redress of £1,000 to Mr D for the injustice he has suffered – the distress he endured as a result of their poor complaint handling.

49. Both Mr D and the Trust have accepted our findings and recommendations.

Conclusion

50. In this report I have set out our investigation, findings, conclusions and decision with regard to the service Mr D received from the Trust. I hope this report will provide Mr D with the outcomes he seeks and bring this unfortunate case to a close.

Complaint about inappropriate email

Contents

The complaint

1. Mr D complained about email correspondence sent between University Hospitals of Morecambe Bay NHS Foundation Trust's (the Trust) customer care manager and the Trust's head of midwifery on 10 June 2010. He complained that the content of that correspondence was offensive to him and his family, particularly his wife, who is Vietnamese. He also complained about the Trust's response to his complaint about that email correspondence. Mr D said that since his baby son's death in 2008 (which happened nine days after his birth at the Trust's Furness General Hospital) the Trust has '*viewed* [him] *as an issue – a problem they wanted to go away*'.

2. Mr D said that he and his family have been caused distress by the content of the emails, and suffered further distress and frustration because of the Trust's response to his complaint.

3. Mr D said he would like: an explanation regarding the emails and an apology from those involved; for the Trust to say whether they found the emails complained about unacceptable; a summary of the Trust's internal investigation regarding the emails; to know whether the Trust have found other offensive communications; and to know whether '*the Trust have taken any action to reduce the chance of other families being exposed to this kind of behaviour in the future*'.

The decision

4. I uphold Mr D's complaint. This is because I have found maladministration in the actions of the head of midwifery and the Trust, which resulted in an injustice to Mr D and his family. The head of midwifery's email was not respectful and, in their response to Mr D's complaint about that email correspondence, the Trust were not 'open and accountable' or 'customer focused'. I have made recommendations and I am satisfied that, once complied with, these recommendations will provide a suitable response to what has happened. I explain why in this report.

Our role and approach to considering complaints

5. Our role[1] is to consider complaints about the NHS in England. We start by considering whether there is evidence that there has been maladministration by an NHS organisation, a failure in a service it provided or a failure to provide a service it was empowered to provide. If so, we consider whether that led to an injustice or hardship.

How we decided whether to uphold this complaint

6. When considering a complaint, we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure.

7. We then consider whether that has led to an injustice or hardship that has not been put right. If we find an injustice that has not been put right, we will recommend action. Our recommendations might include asking the organisation to apologise or to pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation take action to stop the same mistakes happening again.

The relevant standards in this case

8. Our Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[2] are broad statements of what public organisations should do to deliver good administration, provide good customer service and respond properly when things go wrong.

9. The Principles of Good Administration particularly relevant to this complaint are:

   - '*Being open and accountable*' – which includes public organisations being transparent and providing clear, accurate and complete information while respecting the privacy of personal and confidential information.
   - '*Acting fairly and proportionately*' – which includes dealing with people fairly, and with respect and courtesy.

10. The Principles of Good Complaint Handling that are particularly relevant to this complaint are:

    - '*Being open and accountable*' – which includes providing evidenced-based explanations and giving reasons for decisions.
    - '*Acting fairly and proportionately*' – which includes public organisations investigating complaints thoroughly and fairly, and acting fairly towards staff complained about, as well as towards complainants.

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1 Our role is formally set out in the *Health Service Commissioners Act 1993*.

2 You can find more detail about our Principles at www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples.

- '*Putting things right*' – which includes acknowledging mistakes and apologising where appropriate, and providing appropriate remedies.

11. The Principle for Remedy that is particularly relevant to this complaint is:

    - '*Being customer focused*' – which includes providing remedies that take account of people's individual circumstances.

The investigation

12. We have looked at all the relevant evidence for this case, including the papers showing how the Trust handled Mr D's complaint. We also spoke to Mr D, and asked the customer care manager and the head of midwifery to explain why they wrote what they did on 10 June 2010 and what was meant. The Trust, the customer care manager and the head of midwifery have had the opportunity to comment on a draft of this report, as has Mr D, and their responses have been considered. I have not included in this report everything we looked at during the investigation, but I have included everything important to the complaint and to my findings.

Contextual information

13. In November 2008 Mr D's son, G, died nine days after his birth at the Trust's Furness General Hospital. Mr D has since pursued a complaint about his son's death and raised concerns about the Trust's maternity services.

14. In August 2009 midwives from the Trust were under investigation by the Nursing and Midwifery Council (the NMC) in relation to their conduct and practice around G's death. An email that contained one of the midwives' draft responses to the NMC's questions was sent from a Trust computer on 10 August. However, it was misdirected. Mr D was informed that an email containing personal information about the D family had been sent to the wrong email address. The Trust told Mr D that the misdirected email was a '*comprehensive, professional account of* [the midwife's] *recollection of events*'. He later discovered that this email was entitled '*NMC shit*'.

15. Mr D was concerned about this incident and the title of the email, and complained to the Trust. His subsequent complaint to us about this matter was upheld. We found that the Trust were not 'open and accountable' in either their description of the misdirected email or their response to Mr D's complaint about the incident.

Key events

16. On 10 June 2010 at 10.35am Mr D sent an email to the customer care manager explaining that he was '*becoming extremely distressed and anxious about*' the progress of his complaint about his son's death. He wrote:

> '*... I* [realise] *that I need to step back now and that I'm not going to achieve anything else from my efforts, which would be better spent on looking after the family I still have.*
>
> '*Please inform* [the chief executive] *that I do not want replies to any of my recent letters and that moving forward I want the inquest to take its course and the Trust to continue efforts to make sure what happened to* [G] *doesn't happen again. I cannot have done any more to raise aware*[ness] *of the deep concerns I have but it is up to the Trust and the Regulators to act on these ... .*'

17. The customer care manager emailed the head of midwifery the same day at 3.38pm, saying that there was '*Good news to pass on re* [Mr D]'. The head of midwifery replied at 7pm: '*Has* [Mr D] *moved to Thailand? What is the good news?*'.

18. In March 2011 the head of midwifery took a career break from the Trust to volunteer abroad.

Mr D's complaint to the Trust

19. Mr D became aware of this email correspondence when he obtained a large amount of information from the Trust under the *Data Protection Act 1998* in August 2012. On 8, 9 and 10 August 2012 he sent emails to the Trust complaining about the email correspondence and, on

12 August, he wrote an email to the Trust that read:

> *'... here we are again faced with yet more upsetting remarks, which demonstrate the deeply unpleasant and uncaring attitude which some staff at the Trust have in relation to* [G]*'s death and my family.'*

20. At this time Mr D told his local newspaper – the *North West Evening Mail* – that he felt this email correspondence '*hint*[ed] *at an underlying prejudice*'. The news article continued: '*Mr* [D] *said the latest email exchange is "deeply offensive and hurtful" but "sadly typical" of the attitude towards his son's death*'.

21. On 15 August 2012 the Trust told Mr D that the executive chief nurse had, on being made aware on 2 August of the content of the email correspondence, '*asked for an investigation to commence immediately*'.

22. The Trust updated Mr D on 7 September 2012. They wrote:

> *'Following the discovery of a further email*[3] *which we felt was inappropriate, we instructed the division responsible to conduct an investigation into this matter. We are in the process of reviewing a large number of emails that have been sent and released to you and we aim to have completed this process by the end of September.*
>
> *'Please accept our sincere apologies for the further distress that these emails have caused you and your family ...*
>
> *'The Trust is required to investigate this matter fully before taking disciplinary action, if any ...'*

23. The investigation was conducted by the general manager for the women and children's division and completed at the end of September 2012. The report read:

> *'... Terms of reference for the investigation*
>
> - *'To review email correspondence between* [the head of midwifery], [the customer service manager] *and* [the maternity risk manager] *to ascertain if there were any emails that may cause offence or distress.*
>
> *'The search of email correspondence took place on 15 and 16 August 2012 and was undertaken by the Trust's Informatics Service ... Following the email search a total of 1502 emails were identified between the correspondents. All 1502 emails were read and assessed by an independent person. The independent person was an employee of the Trust who did not personally know any of the correspondents.*
>
> *'I can confirm that no further emails contained content which could cause offence or distress.'*

24. On 28 September 2012 the Trust confirmed by email to Mr D that their investigation was complete and that the Trust was considering the outcome. On the same day, the assistant chief executive drafted a letter to Mr D for approval by the Trust's solicitor and the deputy director of human resources. In a covering email, the assistant chief executive described her draft letter as '*circumspect*'.

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3 The Trust have confirmed that the '*further email*' referred to is the correspondence of 10 June 2010.

25. On 8 October 2012 the Trust sent Mr D the following response to his complaint:

> '... [the] *investigation has now taken place and has concluded. The Trust will take any appropriate action necessary as a result of the findings of the investigation. Unfortunately the Trust is unable to give you any further information regarding any action taken due to its obligations under the Data Protection Act 1998.*
>
> *'I would like to take this opportunity to apologise once again for any distress caused to you and your family by the original email correspondence. The Trust expects all staff to act in a respectful, sensitive and professional manner at all times and any behaviour that does not meet these standards is considered to be unacceptable.'*

26. Mr D complained to us on 9 October 2012. He said that he found the Trust's response to his complaint '*completely unacceptable*' because the Trust did not:

- confirm whether this was an isolated incident or whether other offensive communications had been found;
- say whether they found the email communication of 10 June 2010 to be '*unacceptable*'; or
- offer an explanation for the email communication or an apology from the staff involved.

27. Overall, Mr D said that the Trust had not been 'open and accountable' in its response.

Events since Mr D complained to us

28. A meeting took place on 13 December 2012 between the customer care manager, the head of nursing and the assistant chief executive to discuss the email correspondence. The notes of that meeting include the following:

> '[The customer care manager] *said she was sorry the meaning of her words had been misinterpreted by* [Mr D] *and that she would be happy to explain her intended meaning in a letter to* [Mr D] *or at a meeting with him. Discussion took place whether it would be appropriate or not to send such a letter but it was suggested that a letter would be drafted from the chief executive ... quoting wording provided by* [the customer care manager].'

29. The Trust has since confirmed to us that no letter such as that described in these notes was ever sent to Mr D. They say that this is because, shortly after the meeting, they became aware that we intended to investigate.

The Trust's comments

30. In response to our proposal to investigate Mr D's complaint the Trust wrote in February 2013: '*The Trust is now in the process of concluding a disciplinary investigation into this issue however the individual concerned remains overseas*'.

31. On 11 April 2013 we asked the Trust to explain what, if any, other action it took to investigate the email correspondence of 10 June 2010. The Trust replied:

> '... [the former head of midwifery] *was interviewed on 26 March 2013 in relation, amongst other issues, to the email that she sent* [the customer care manager] *on 10 June 2010. Draft meeting notes have been prepared following this meeting in which* [the former head of midwifery] *states:*
>
> > *"I don't understand the reference to Thailand; I've no memory of making that point. I know his wife is from Vietnam ... by that time I had applied to work with* [Voluntary Service Overseas] *... Thailand was very much in my mind ... Why I've made that comment it is* [sic] *completely out of character, it's embarrassing.""*

32. The Trust went on to explain that because of a dispute about whether or not the former head of midwifery is still a member of Trust staff '*no further work has been undertaken on the investigation*'.

The customer care manager's statement

33. We asked the customer care manager for a statement explaining why she wrote what she did on 10 June 2010 and what was meant. She provided the following:

> *'... I received the email from the complainant advising that he had made a decision to step back from further contact with the Trust in pursuit of his concerns, due to the effect it was having on him; he also telephoned me to confirm this. I forwarded the email to the Chief Executive, Medical Director and Nursing Director, advising them that I had passed on the best wishes of the Chief Executive and had also assured him that work would continue to raise the standard of Maternity Services. I later* [in response to an email she had received from the head of midwifery about an unrelated matter, she emailed the head of midwifery and] *... made the "Good news" comment.*
>
> *'I had been the complainant's primary point of contact with the Trust since he first raised concerns about the care of his wife and son and believed I had formed a good relationship with him and that he accepted I was genuinely concerned for his welfare. We had had many lengthy conversations and during some of these he was clearly distressed and related how he was feeling at those times.* [The head of midwifery] *had previously verbalised her concerns about the complainant's well-being to me. I was fully aware that there was an inquest pending and that issues identified by this case were being followed up by a number of agencies. I honestly believed that the work to continue* [improving] *Maternity Services would progress whether or not the complainant remained personally involved.*

'The "Good news" comment ... was therefore made in relation to the complainant's well-being and nothing more as I believed she had shared my concerns for his welfare. On receipt of [the head of midwifery's] *response at the end of the email chain, I did not reply ...*

'I truly regret that my comment has unintentionally caused distress to the complainant and his family. I am very sorry that the complainant misinterpreted my comment but recognise why this is the case. I would like to offer him and his family my sincere apologies and wish to emphasise that I in no way intended to be disrespectful — I have always had great sympathy for them and continue to do so. I hope that the complainant is able to accept my explanation ... I always endeavoured to represent his concerns and feeling[s] *to colleagues in the Trust throughout my years of contact with him.'*

34. The customer care manager's statement also included some information about how the Trust had handled Mr D's complaint about the email correspondence:

'When the complainant submitted his complaint by email last August he included me on the circulation and I immediately forwarded it to the Chief Executive and Head of Communications offering to provide an explanation. I was informed by the Nursing Director that the division were carrying out an investigation and that relevant staff would be contacted to provide a statement. I was not contacted and, on making enquiries (around last October, I think) as to whether a response had been sent, I was informed that a letter had gone to the complainant; I have never seen that letter.

'I was later seen by the Head of Nursing and Assistant Chief Executive on 13 December [2012] *and asked about the email chain. I stated that I was sorry the comment had been misinterpreted and would be happy to meet with the complainant and provide an explanation to him, or to do so in a letter to him, perhaps to be sent under cover of a letter from the Chief Executive. It was suggested that a paragraph of explanation be provided by me, to be included in a letter from the Chief Executive and I provided this by email to the Head of Nursing on the following day ... .'*

The head of midwifery's statement

35. We asked the head of midwifery for a statement explaining why she wrote what she did on 10 June 2010 and what was meant. She provided the following:

'... I am writing this to the best of my memory and based on my usual practice ... [I] *cannot recall every detail ...*

'... I think I remember that [Mr D] *intended to spend an extended holiday in South East Asia. I cannot remember if the holiday was before or after the*

10 June [2010]. *I remember that he has lived and worked there before and therefore maybe wondered if he was going to live there again.*

'At the same time, I had applied to work as a volunteer clinical midwife with [Voluntary Service Overseas and] *International and South East Asia was my first choice of posting ... What I can say with absolute certainty is that the comment about Thailand had no racial prejudice connotations whatsoever and I was deeply distressed and sorry that Mr* [D] *... or others might interpret it this way.*

'At 19.00 hours on 10 June 2010, the day before I was to start annual leave, I know I would be very tired and stressed, I am guessing that I did get Thailand and Vietnam confused perhaps as I was reading a lot at the time about Thailand as I thought [Voluntary Service Overseas] *may propose sending me there. I know that Mrs* [D] *is from Vietnam.*

'... I welcome this opportunity to try to explain the comment but this is difficult as I do not remember making it, I apologise if I have got some of the details not quite accurate. I also welcome the opportunity to apologise for the comment causing distress – I am certain it was entirely unintentional, but ... I cannot remember the exact circumstances leading me to write it.'

Further information from the customer care manager

36. In a telephone conversation with the customer care manager on 6 June 2013 we asked her if she had any idea why the head of midwifery made the reference to Thailand. The customer care manager replied, '*No, only that we were dealing with a number of cases at that time involving mothers from ethnic minorities*'.

Findings

37. The customer care manager should have, in accordance with the Principles of Good Administration, acted fairly towards Mr D and treated him with respect. I am persuaded by the customer care manager's statement that she was concerned for Mr D's well-being and that this is what prompted her to describe Mr D's decision to '*step back*' from his complaint regarding his son's death as '*Good news*'. However, by using words which were open to misinterpretation, she gave the impression that she agreed that Mr D should stop his '*efforts to make sure what happened to* [G] [didn't] *happen again*'; and that she would be relieved not to have to deal with him. I can quite understand how, on discovering this email correspondence, Mr D interpreted the content as '*deeply unpleasant and uncaring*', and felt that the Trust '*viewed* [him] *as ... a problem they wanted to go away*'. Mr D had, after all, described himself in his email as '*extremely distressed and anxious*', and the customer care manager passed this on as '*Good news*'.

38. The customer care manager should have been more conscious that her words could be misinterpreted as being disrespectful to Mr D and the tragic circumstances that had led to his complaint. Her choice of words was ill-judged. However, because her intention was, I believe, to reflect her genuine concern for Mr D, I do not think that her actions amounted to maladministration. I note that she has said that she truly regrets the distress she has caused Mr D.

39. The head of midwifery should similarly have acted in accordance with the Principles of Good Administration by being fair to Mr D and respectful when she replied to the customer care manager's email. However, her reply indicated that she would regard Mr D moving to another continent as '*Good news*'. This was disrespectful and created an impression that she would have liked Mr D to '*go away*'.

40. Mr D believes that his wife's ethnicity is, albeit inaccurately, referred to in the head of midwifery's reply, and that it '*hint*[ed] *at an underlying prejudice*'. The head of midwifery says that she only mentioned Thailand because, for personal reasons, that country was '*very much in* [her] *mind*' at that time. It seems highly unlikely that her decision to mention a country so close to the area of the world that Mrs D is from was a coincidence and completely unrelated to Mrs D's ethnicity. Indeed, she goes some way to admitting that it was a reference to Mrs D; she said in her statement '*I am guessing that I did get Thailand and Vietnam confused ... I know that Mrs* [D] *is from Vietnam*'. Her email therefore shows that she had Mrs D's ethnicity in mind when thinking about this family. That said, I cannot go so far as to say that her response reveals any racial or ethnic '*prejudice*'. I can only conclude that, for the head of midwifery, '*Good news*' would have been news that Mr D was moving far away. That in itself is not in line with the principle of '*Acting fairly and proportionately*'. I find that the head of midwifery's email fell so far below the standards of respect and courtesy to be expected in these circumstances that it amounted to maladministration.

41. When Mr D became aware of this email correspondence and made his complaint about it, he was entitled to expect that the Trust would be: 'open and accountable' by providing him with a transparent, clear, complete and evidence-based explanation; 'fair and proportionate' by investigating his complaint thoroughly; and that they would 'put things right' and be 'customer focused' by providing a remedy that took account of his individual circumstances.

42. Although I recognise that the Trust explicitly said, in their letter of 7 September 2012, that the email correspondence of 10 June 2010 was '*inappropriate*', and also offered a '*sincere apolog*[y]', I do not consider that the Trust conducted a thorough investigation of this incident. The Trust reviewed a significant amount of email correspondence but they did not seek to understand why the individuals had written what they did or what was meant. Seeking to understand this was particularly important, given Mr D's obvious concern that the head of midwifery's words were, in some way, racially motivated. The Trust did not seek statements from the customer care manager or the head of midwifery until long after their final response to the complaint had been sent on 8 October 2012. (The customer care manager was spoken to in December 2012 and the head of midwifery was spoken to in March 2013.) The customer care manager was clearly willing to provide her explanation quite early in the complaint, but the Trust did not contact her.

43. The Trust's response of 8 October 2012 rightly sought to respect the privacy of personal and confidential information relating to their staff. It also included a further apology. However, the Trust's response did not give sufficiently clear or complete information to demonstrate what investigation and action had taken place. The letter was not transparent. The Trust did not use the evidence acquired from the investigation to confirm to Mr D that '*no further emails contain*[ing] *content which could cause offence or distress*' had been found. Nor did they explicitly say that the email correspondence of 10 June 2013 was '*unacceptable*'. Furthermore, the Trust could not offer any reassurance, apologies or explanations from the staff involved because they had not, at that stage, been spoken to.

44. The Trust also failed to provide Mr D with an appropriate remedy that took into account his individual circumstances (Principles for Remedy). The Trust should have taken into account the fact that Mr D had already had cause to complain about an email which was disrespectfully titled '*NMC shit*'.

45. Overall, I find that the Trust were not 'open and accountable' and failed to 'put things right' or act in a 'customer focused' way. Their response to Mr D's complaint about the email correspondence fell short in so many respects that it amounted to maladministration.

Injustice

46. I now consider whether the maladministration I have identified led to an injustice to Mr D.

47. Mr D says that he and his family have been caused distress by the content of the emails, and suffered further distress and frustration because of the Trust's response to his complaint. As I have already acknowledged, I can quite understand how, on discovering this email correspondence, Mr D interpreted the content as '*deeply unpleasant and uncaring*', and felt that the Trust '*viewed* [him] *as ... a problem they wanted to go away*'. Although the customer care manager's part in the exchange was, I believe, well-intentioned and did not amount to maladministration, the head of midwifery's words were disrespectful and undoubtedly caused Mr D and his family upset and distress. This was an injustice which was compounded by the Trust's failure to conduct a thorough investigation of his complaint.

48. As a consequence of the Trust's maladministration in this case, Mr D was left without any explanation for the email correspondence, no meaningful apology, and no reassurance about the existence of further emails. I can appreciate that this caused Mr D further distress and frustration. This was an injustice.

Recommendations

49. I have considered my findings in the light of our Principles for Remedy. Two of these Principles are particularly relevant here:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation or remedial action); and
    - '*Seeking continuous improvement*' – which includes using the lessons learnt from complaints to ensure that maladministration or poor service is not repeated.

50. I recommend that the Trust should, within one month of the date of this final report:

    - provide Mr D with an acknowledgement of the failings identified in this report and an apology for the consequential injustice; and
    - consider what it can do now to rebuild the relationship with Mr D;

    and, within three months of the date of this final report, prepare an action plan that:

    - describes what the Trust have done to ensure that the organisation has learnt lessons from the failings identified by this upheld complaint; and
    - details what they have done and/or plan to do, including timescales, to avoid a recurrence of these failings.

51. A copy of the action plan should be sent to:

    - Mr D
    - us
    - the Care Quality Commission (CQC)
    - Monitor, and
    - NHS Cumbria Clinical Commissioning Group.

52. The Trust should also ensure that Mr D, the CQC, Monitor and the clinical commissioning group are updated regularly on progress against the action plan.

53. A copy of the apology letter should be sent to us.

The Trust's and Mr D's response to the draft report

54. In response to a draft of this report, the Trust acknowledged and accepted our findings and recommendations. The customer care manager also accepted our findings and reiterated her apologies to Mr D and his family. She wrote:

    'I hope he knows that I personally have never "viewed [him] *as an issue – a problem* [I] *wanted to go away" and was genuine in my efforts to support him and represent his concerns and feelings.'*

55. The head of midwifery accepted that her email was '*inappropriate*' and apologised '*unreservedly for the distress caused*'. She wrote:

    'I again apologise sincerely to Mr and Mrs [D] *if they felt the comment to be racially prejudiced against her and would like to assure them that there was no prejudice intended ... .'*

56. Mr D accepted our findings and recommendations.

Conclusion

57. In this report I have set out our investigation, findings, conclusions and decision with regard to the service Mr D received from the Trust. I have found maladministration in the head of midwifery's part in the email correspondence, and I have found maladministration in the Trust's handling of Mr D's complaint about this. The identified maladministration has caused Mr D the injustice of distress. I therefore uphold the complaint about the Trust. I am satisfied that my recommendations will remedy the failings identified.

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