

The Ombudsman's Casework Report 2019



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Foreword

Welcome to the first annual Ombudsman's Casework Report. This report covers decisions we made in 2019.

I am publishing this report as part of our commitment to becoming more transparent. We can only get the best value from the Ombudsman service when our findings are shared widely. I want public services to learn from the experiences and findings we have set out here.

The Ombudsman service is vital in achieving justice for people who have suffered harm or hardship as a result of failures in public service. This is particularly so for the most vulnerable in society whose voices might not otherwise be heard.

Complaints are essential feedback for public services. It is crucial that public services have a culture of learning, one that values complaints as a driver of improvement.

Leaders have a responsibility to lead by example, creating an environment where complaints are a way to listen to service users, build trust and provide better services. Leaders at every level and in every public service should set the tone for complaints to be valued to ensure delivery of the quality service our citizens expect and deserve. Although many of the complaints we receive reflect very serious and sometimes life-changing failings, public services can and do also change lives for the better.

The Ombudsman is the final step in the complaints process. We are here to achieve justice for those who have been failed. When we uphold a complaint, people have not just been failed by a public service, but also by failings in the complaints system.

The complaints system can be too long,

complicated and overly onerous on the complainant. People bringing complaints to us may have persevered with their complaint for considerable lengths of time, negotiating what is sometimes a convoluted and confusing process. The stress this puts on people seeking answers cannot be underestimated.

People need to understand what to expect if they want to complain. It is the lack of this shared understanding of good practice that makes the process of complaining so stressful and puts the burden on the complainer. In March 2020, we will be consulting on a Complaint Standards Framework which will provide a common set of expectations.

Complaints can also have a significant impact on the public servants involved too. This is why complaints should be seen as an opportunity to learn and improve, not to blame individuals who may work in challenging and stressful situations. The Complaint Standards Framework will help public services deliver a better complaints service and make sure complaints are integrated into the culture of the organisation.

The best organisations use every opportunity to embrace complaints to deliver a better service. This report is a way to share that learning across public services and help drive wider improvements.

Rob Behrens, CBE
Parliamentary and Health Service
Ombudsman

Executive summary

We make final decisions on complaints that have not been resolved by the NHS in England, UK government departments and other UK public organisations.

We look into complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right. We look into complaints fairly, and our service is free for everyone.

This first annual Ombudsman's Casework Report highlights the breadth of cases we receive across our jurisdictions. It is only a small cross section of the cases we completed in 2019. The complaints presented here are typical of many of the complaints we see across our remit. They include complaints about government bodies and the NHS.

Unlike the usual casework reports that we lay before Parliament, the complaints included here are not thematic or related to a specific incident or body. Instead, these new annual Ombudsman Casework Reports will share some of our most significant findings from cases completed over the year.

The cases in this report cover a wide range of areas including ensuring people receive the child support they are entitled to, the support of British nationals overseas, cancer diagnosis and providing appropriate and effective mental health treatment.

We hope that this report proves useful for relevant Select Committee Chairs to scrutinise departments about general issues of administration. In particular, where departments and their agencies have indicated they will take action to embed learning from the mistakes they made. This is highlighted in the recommendations in each summary.

We encourage public bodies to learn from the cases we have included, not just in terms of improving frontline services but also in their own complaint handling.

A more transparent Ombudsman service

This report is a significant part of our aim to be more transparent in our work. We are now publishing much more data about the complaints we receive. In December 2019, we published all the [recommendations we made from April to June 2019](#). By April 2021, we will begin publishing the majority of our decisions anonymously.

We regularly publish reports that draw on themes in our casework. For example, in 2019 we published [Missed Opportunities: what lessons can be learned from failings at the North Essex Partnership University NHS Trust](#).


We will also shortly be publishing an insight report on how NHS organisations handle complaints, as part of our strategic commitment to improve frontline complaint handling. That report will highlight key themes from casework in this area and share insight from frontline staff, as well as advocacy organisations and people who use NHS services.

We will publish this insight report alongside a consultation on a draft Complaint Standards Framework. This framework aims to set out a unified vision of good complaint handling for public services, beginning with the NHS. Our report will highlight how such a framework can make a difference, as well as the importance of investing in and professionalising staff who deal with complaints and feedback on the frontline.

As the final stage in the complaints process, we do not see all the good examples of public service. There is no doubt that many people receive good service, whether this is from a

local benefits team or a large hospital trust.

Nonetheless, complaints are a vital source of learning. Public services should look at complaints openly and honestly and seek to use them to drive continuous improvement. As we publish more information about the complaints we see, we hope organisations can take the opportunity to learn from the mistakes of others to ensure people get the level of service they are entitled to.



‘... complaints are a vital source of learning. Public services should look at complaints openly and honestly and seek to use complaints to drive continuous improvement.’

Complaints about UK government bodies and other public organisations

The Parliamentary Ombudsman was established in 1967. In 1973 we gained powers to look at complaints about the NHS in England, and clinical matters came under our jurisdiction following further legislative changes in 1993.

We are the UK Parliament's Ombudsman. This means we are independent of government and support the work of Parliament in holding public organisations to account. We report directly to Parliament through the Public Administration and Constitutional Affairs Committee (PACAC).

Although complaints in our parliamentary jurisdiction are the most longstanding part of our work, they currently make up only a small percentage of our casework. This is due to an outdated law where the Ombudsman can only look at complaints that have been referred by a person's MP. This is called the MP filter.

The MP filter is an unnecessary restriction on people's ability to access justice by complaining to the Ombudsman. It was part of the original 1967 law that set up the office, and the Government at the time committed to review it after the office had been established for a few years. This review never happened, and we are left as one of the few Ombudsman schemes in the UK and internationally with this barrier to accessing our service. In 2016, the Government published a draft bill that would have established a single Public Service Ombudsman. This draft bill would have removed the MP filter, but no progress has been made on introducing this legislation.

Before the recent general election, we asked party leaders to make progress on Ombudsman reform in the new Parliament

and commit to improving the draft legislation produced three years ago. We called for significant, modernising changes to the draft, including the addition of complaint standards and own initiative powers that are increasingly commonplace across other UK and international ombudsmen. Since the legislation was produced, the Council of Europe's Venice Principles for the protection and promotion of Ombudsman institutions have also been published and adopted. Any legislative proposals now need to be tested against these principles in pre-legislative scrutiny by a joint committee in Parliament.

The cases presented in this report are a selection of the types of complaints we receive. Although we cover over 300 public organisations, most of the complaints we receive in our parliamentary jurisdiction are from four central government departments and their public-facing agencies. These are the Department for Work and Pensions (DWP), the Ministry of Justice (MoJ), the Home Office (HO) and Her Majesty's Revenue and Customs (HMRC).

Child Support Agency failed to ensure a parent got £10,000 in child support arrears.

Organisations: Child Support Agency and Independent Case Examiner

The complaint

Complainant D complained that the Child Support Agency (CSA) did not do enough to ensure the proceeds from the sale of Person G's property were secured to pay off child support arrears and had not accepted its failings.

Complainant D also complained that the Independent Case Examiner (ICE) carried out a flawed investigation into her concerns. The ICE is the second-tier complaint handler for the CSA and other government organisations that deal with benefits, work and financial support.

Complainant D told us that as a result of the CSA's failings, Person G was able to sell a property without paying approximately £10,000 in arrears of child support.

The background

Complainant D had a child with Person G. Their relationship broke down and Person G was responsible for paying child support to Complainant D, which they did not pay. Complainant D had a long-standing child maintenance case with CSA. For the purposes of child support, Person G was classed as a Non-Resident Parent (NRP).

CSA can apply to the court for a charging order on an NRP's property in relation to child support arrears owed to a parent with care of a child or children. A charging order places a restriction on the sale of the property. In this case, any sale of the property by the NRP could not proceed without first notifying CSA. To force the sale of the property, CSA can apply for an Order for Sale.

An Order for Sale effectively gives CSA the ability to sell a property to settle the debt owed. If the owner sells the property themselves, this would breach the Order for Sale. However, if a sale took place despite the Order for Sale, the sale would be binding and could not be reversed.

Person G bought the property in question with another person. Over a four-year period, CSA obtained four charging orders on the property. These said CSA should be notified before any sale of the property could take place.

CSA was then granted an Order for Sale against the property. One condition of the Order was that a valuation be undertaken within 28 days. If the debt was not paid by Person G within three months, the Order for Sale said Person G should deliver possession of the property to CSA. CSA sought a valuation two months after the deadline set in the Order for Sale and five days after the deadline set for Person G to vacate the property.

One month after the deadline to secure possession of the property, an estate agent conducted an external valuation and delivered the report to CSA. The estate agent told CSA it had previously undertaken a valuation of the property for Person G. The estate agent told CSA the property was sold subject to contract with another estate agent.

In accordance with the restriction on the property by the original charging order, Person G's solicitors informed CSA about the forthcoming sale of the property. CSA informed them of the debt owed but did not tell them about the Order for Sale. Person G's solicitors said they would take instruction from their client (Person G).

The property was then sold outside the terms of the Order for Sale.

Complainant D complained to CSA and subsequently to the ICE as the second tier complaint handler. Complainant D was dissatisfied by the responses and brought her complaint to us.

What we found

CSA did not comply with the conditions of the Order for Sale. CSA sought a valuation of the property after the deadline set by the court. There was no reason for CSA to have acted outside the conditions of the Order for Sale. CSA should have done more to proceed with the Order for Sale within the deadlines set by the court, given Person G's history of non-payment of child support.

CSA took no action to secure possession of the property by the deadline set in the Order for Sale and made no record of any decisions taken about why it did not take action to do so.

CSA did not tell Person G's solicitors about the Order for Sale. This would have placed an onus on the solicitors to abide by the terms of the Order for Sale. CSA could also have considered requesting an undertaking (a legally binding promise) from the solicitors to settle the arrears of child support through the sale of the property. CSA's failures effectively enabled the sale of the property in breach of the Order for Sale.

Even following the sale of the property, we found CSA did not do enough to ensure Person G settled the debt owed. CSA made no record of the reasons why it did not pursue other options, such as a freezing order on the monies received from the sale of the property to prevent them being disposed of.

We did not find any failings in relation to the Independent Case Examiner's handling of the complaint.

Putting it right

CSA should have secured the child support arrears owed to Complainant D through the Order for Sale. Not doing so left Complainant D without the money they were owed. CSA's handling of the complaint caused Complainant D distress, inconvenience and frustration. To put this right, we recommended the CSA:

- Apologise to D for the impact of its failings
- Pay D £10,018.27 in compensation for the child support arrears they would have received but for the failings by CSA, plus interest
- Pay D £2,000 for the inconvenience, distress and frustration caused by the CSA's handling of the complaint
- Review the learning from the case, including relevant policy and procedures when pursuing an Order for Sale where there is a history of non-payment of debt by an NRP.

CSA has fully complied with our recommendations.



Communication of changes to inflation of state pensions

Organisation: Department for Work and Pensions

The complaints

Complainants N and T complained that the Department for Work and Pensions (DWP) failed to communicate that the introduction of the new state pension system could have a negative long-term impact on people.

Background

Before 2016, the state pension was in two parts, the basic state pension which everyone of State Pension Age got, and the second state pension, which was dependent on people making further National Insurance Contributions (NICs). Employers could also 'contract out' from the second state pension and give their employees a private Guaranteed Minimum Pension (GMP) instead. Contracting out meant both the employer and employee paid lower NICs.

When people with GMPs reached State Pension Age, DWP carried out an annual comparison to check if they were receiving the same as they would have done if they had not 'contracted out' of the second state pension. The aim was to ensure those with second state pensions and those with GMPs received roughly the same amount after they reached State Pension Age. This annual calculation meant that DWP essentially paid inflationary increases (indexation) to some people with GMPs.

In April 2016 those reaching State Pension Age had the basic and second state pensions replaced by the new State Pension. The amount people get from the new State Pension depends on their NICs. People who had previously 'contracted out' from the second

state pension made lower NICs, so their starting amount was lower than those who had 'contracted in'. Those who contracted out would continue to receive their GMP through their employer's pension scheme.

However, DWP no longer compared the amount people received from their GMP with what they would have got if they had 'contracted in' to the second state pension.

Those reaching State Pension Age after April 2016 who had contracted out for long periods no longer benefited from inflationary increases from DWP. Those who did not contract out received annual inflationary increases on the additional NICs to their second state pension. This could amount to a person with a GMP receiving much less than they were expecting to over the course of their retirement, and less than they would receive had they not 'contracted out'.

When communicating this change, DWP did not explain that people with long periods of contracting out could be significantly worse off. It instead chose to focus only on the benefits of the new State Pension and other separate pension changes. DWP said:

- that any negative impacts for those with GMPs would be offset by making further NICs, so that individuals could receive the full amount of the new State Pension
- an uplift announced to all pensions in 2011 (called the triple lock) would offset any negative impacts.

Complainants N and T both reached State Pension Age after the pension reforms took effect and began receiving the new State Pension. They had long periods of contracting out and, therefore, had large GMPs and lower NICs. The amount they received through the new State Pension was roughly the same as it would have been if they received the basic state pension (in place before 2016).

However, they would no longer be entitled to inflationary increases, which they were likely to have received if the annual comparison between GMPs and the second state pension had continued to take place.

As a result, over the course of their retirement, Complainant N and Complainant T anticipated losing out on payment of many thousands of pounds from DWP that they would have received under the old system.

What we found

Our investigation focused on how DWP communicated with individuals in order to help them plan for their financial future.

DWP was aware the pension changes could negatively affect people with long periods of contracting out who were due to reach State Pension Age shortly after the new State Pension was introduced. However, DWP used flawed arguments, saying that negative impacts could be offset for those with long periods of contracting out who were due to reach State Pension Age shortly after April 2016. Despite what DWP argued, we considered:

- these individuals would not be able to make more NICs to offset any negative impacts
- as the triple lock applied to everyone, it would not offset any negative impacts for these individuals in comparison to other groups.

DWP failed to provide clear, accurate and complete information through its pension forecasts, impact assessments and other literature. This was despite being warned by both the National Audit Office and the Work and Pensions Select Committee that better communication was needed for those with long periods of contracting out.

DWP failed to make clear that some people could be worse off as a result of the pension reforms. This meant that some individuals were

not aware that they might need to consider seeking independent financial advice and might need to make alternative provision for their retirement.

In Complainant N's case, Complainant N recognised that DWP used flawed arguments. Whilst DWP's actions did not prevent Complainant N from planning for their financial future, dealing with DWP's inadequate responses to their concerns caused frustration.

In Complainant T's case, DWP's inadequate responses meant Complainant T was not aware until March 2015 that the pension reforms could have a negative impact on them. As Complainant T had retired before 2010, even if DWP had communicated properly it was unlikely they could have taken steps to make a substantive difference to their finances. However, the loss of a longer window of opportunity and the belief that they might have been able to make a difference to their financial situation was an injustice.

Putting it right

As a result of our findings, we recommended DWP should review and report back its learning from our investigations. In particular, it should ensure that its literature clearly and appropriately points out that some individuals who have large GMPs and reach State Pension Age in the early years may be negatively affected by the changes. It should explicitly tell people to check their circumstances and should provide details to the public about how they can do this.

We also recommended that DWP apologises to Complainants N and T for the frustration and inconvenience its actions caused and pay them £500 and £750 respectively.

DWP is due to report back to us on our recommendations by the end of February 2020.

Failures in communication caused lost income for sea bass fishers

Organisation: Marine Management Organisation

The complaints

Complainants D and V complained to us about how the Marine Management Organisation (MMO) handled issues relating to the process of authorising boats to fish for sea bass.

Complainant D complained to us that MMO provided incorrect information about the entitlement of boat A to fish for sea bass and that it incorrectly removed boat A's entitlement and transferred it to a different boat.

Complainant V complained that MMO did not provide clear information about what supporting information it needed so that they could get authorisation to fish for sea bass using the specific fishing method of hook and line.

Complainants D and V told us that the process caused them distress and affected their income. Complainant D said that they were not able to use their boat to fish. Complainant V said that because their boat did not have authorisation to fish for sea bass by hook and line, an employee left, meaning they were forced to work longer days on their own and they were not able to work as much as they would have liked.

Background

MMO put a new process in place to authorise boats to fish for sea bass. There are different ways to fish for sea bass and the authorisation also stated which specific ways a boat could use to fish for sea bass. MMO had a specialist team that handled applications for sea bass fishing. MMO also had public guidance to explain how to appeal a decision, as well as internal guidance explaining when an appeal would be successful.

Complainant D wanted to buy a boat that had permission to fish for sea bass. They found a boat that someone else owned and wanted to buy it. Complainant D called their local MMO office to find out whether the boat had the authorisation to fish for sea bass. MMO said that the boat had this authorisation. Complainant D bought the boat but the person selling the boat asked the MMO to transfer the authorisation to another boat they owned. Once MMO had transferred the authorisation to a different boat, Complainant D's boat no longer had authorisation to fish for sea bass.

Complainant V applied to MMO to get authorisation to fish for sea bass by hook and line. MMO wrote to Complainant V to tell them that they had permission to fish for sea bass but that they could not use the hook and line method. Complainant V used MMO's guidance to see what evidence they needed to provide to MMO to appeal that decision. Initially, MMO did not give authorisation. Over a year later, MMO gave Complainant V authorisation to fish for sea bass using hook and line.

What we found

When MMO wrote to Complainant V to tell them they did not have permission to use the hook and line method, Complainant V presented MMO with evidence to support their appeal against that decision. Complainant V based their evidence on the guidance available to the public. MMO wrote back explaining that Complainant V could use their boat to fish for sea bass but not by the hook and line method. MMO did not explain the reasons for that decision. We found that MMO should have explained the reasons for its decision when responding to Complainant V.

MMO's internal guidance stated that coastal officers needed to verify that the boat had previously fished for sea bass using the hook and line method. This is called independent coastal verification. The information made available to the public did not include the requirement for independent coastal

verification as part of the process of appealing the decision. The information MMO made available to Complainant V and the general public was inaccurate and incomplete. In addition, the independent coastal verification method was not reliable because coastal staff did not have contact with all boats.

In Complainant D's case, MMO correctly transferred the authorisation to fish for sea bass to a different boat in line with the request made by the previous owner of the boat. However, when Complainant D called their MMO local office, MMO told Complainant D that the boat had authorisation to fish for sea bass. This was not true as MMO had already transferred this authorisation to a different boat. MMO said Complainant D should have contacted MMO's specialist team and that this information was available in a letter it had sent to Complainant D. However, MMO should have told Complainant D to contact the specialist team, rather than give them incorrect information when they contacted the local office.

There was a missed opportunity for Complainant D to make a fully informed decision about buying their boat. This caused Complainant D stress and frustration. In Complainant V's case, they had less income as a result of the MMO's failings in the process of appealing the decision.

Putting it right

In both cases, we recommended that MMO should pay the complainants £3,000 in recognition of the lost opportunity to earn more money and the stress and frustration its process caused. We also recommended that MMO should apologise to Complainant D and Complainant V and should review the learning from each case to improve its services.

MMO have complied with our recommendations in both cases.



UKVI wrongly rejected a visa application for a child, causing three years of distress and uncertainty

Organisation: UK Visas and Immigration (UKVI)

The complaint

Complainant H complained that UKVI rejected two visa applications for Person C. They also complained UKVI took five months to provide Person C's visa once their appeal had been upheld.

Complainant H said they experienced distress and anxiety as a result.

Background

Complainant H wanted to bring Person C to the UK following the death of Person C's mother, Complainant H's adopted sister.

They applied for a settlement visa (indefinite leave to remain) for Person C on grounds of serious compelling and compassionate circumstances. Person C, a child, was living with their elderly grandparents in their home country following the death of Person C's mother shortly after their birth.

The application was rejected as UKVI was not satisfied there were serious and compelling family considerations and there was insufficient evidence of the relationship between Complainant H and Person C.

Complainant H appealed the decision through tribunal. The tribunal concluded that the appeal should be allowed under the immigration rules and Article 8 of the Human Rights Act, the right to a private and family life. The judge was satisfied that there were serious and compelling family considerations

and evidence of the relationship between Complainant H and Person C.

UKVI did not issue a visa after the tribunal decision. Instead UKVI refused the application saying there were safeguarding concerns given the complex relationship between Complainant H and Person C.

Complainant H appealed again to the tribunal, which upheld their appeal. Person C received their visa three years after the initial application.

What we found

Our role in this complaint was to consider whether UKVI made its decisions in accordance with the relevant rules, not the decisions themselves. Complainant H had followed the correct process to question the decision by appealing to the tribunal.

We found that UKVI reached its decision on the first application within the framework it operates under for deciding visa applications. UKVI had considered the available evidence and reached a discretionary decision. The tribunal allowed the appeal against this decision.

UKVI then, however, also rejected the second application, although the tribunal had decided that the visa should have been awarded. UKVI reached this decision because it was now aware that Complainant H was not biologically related to C. UKVI decided this meant the tribunal's decision was not valid.

UKVI made this decision against its own rules. UKVI should have challenged the tribunal's decision and did not. UKVI should then have issued the visa within eight weeks. Instead, UKVI reassessed the application, before rejecting it for the second time.

Following the second tribunal's ruling, UKVI did not delay issuing the visa. UKVI did not receive

the tribunal's determination for almost two months after the decision. Once UKVI received the determination, it undertook the work to issue the visa without delay, issuing the visa within five weeks.

Putting it right

We recommended UKVI pay Complainant H £1,400 in recognition of the distress and inconvenience they suffered.

UKVI complied with our recommendation.

Poor record keeping and supervision of staff left a family with significant emotional impact and uncertainty around decisions made about a child's care

This was a very complex case, involving many parties over several years. Our investigation report was lengthy and focused on the role of the guardian, Cafcass's supervision of the guardian and how it handled Complainant W's complaint.

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

The complaint

Complainants W and L complained that Cafcass had failed Complainant L by allowing them to remain in a placement with a foster carer who they had accused of abuse. They complained Cafcass acted with bias, lied in court and allowed other parties to lie and mislead the court.

Complainants W and L complained that Cafcass had not fully and appropriately responded to their complaint and had withheld information from them.

Complainants W and L said that as a result, they had been separated from each other for four years. They said Cafcass had misrepresented them. They said the experience had been emotionally draining.

Background

Complainant L had been adopted by Complainant W and their partner, Person J. Later, Complainant L began to have contact with a birth parent. Complainant W then separated from Person J.

A letter from a third party was sent to social services with concerns about Complainant L. They had been living with Person J at this time, but soon went to live with youth leaders from their church. After a week, Complainant L went to live with Complainant W but told the local authority they wanted to live somewhere neutral. Complainant L then went to live with Persons I and F, who they knew from church.

The local authority then placed Complainant L on the Child Protection Register under the category of emotional abuse. It considered Complainant W and Person J were involving Complainant L in their disputes. At this point Complainant L indicated that they wished to go and live with their birth parent and family in a different city.

The local authority began care proceedings to secure a long-term plan for Complainant L. This resulted in Cafcass appointing a guardian for Complainant L. The local authority then concluded Complainant L's birth parent was a suitable and safe option, which is where they then went to live. There was then a court hearing about the case. The court ordered that Complainant W, Person J and Complainant L should all be assessed by a psychologist and a psychiatrist.

Complainant L had some trouble settling with their birth parent and continued to have contact with Complainant W and Person J. The guardian liaised with all parties in the case, including social workers and the psychologist and psychiatrist.

Complainant L returned to Complainant W and Person J's hometown, and again stayed with Persons I and F. Complainant L later raised concerns about Person I and inappropriate touching and they were placed into temporary foster care.

Complainant L withdrew the allegations about Person I and decided to return to live with Persons I and F, which the court allowed.

Complainant W raised concerns about this. All parties, including the guardian, social workers and the police, continued to monitor the placement with Persons I and F, and whether it was a safe environment for Complainant L to continue to live.

What we found

Complainant W complained that the guardian had disclosed elements of the psychiatrist and psychologist's reports to Complainant L. We found that it was appropriate for the guardian to do this.

The guardian acted appropriately in supporting Complainant L to live with their birth parent. We found that the guardian was supportive of Complainant L and did not bully or otherwise unduly influence their choices. We also found that the guardian did not act to exclude Complainant W from mediation.

The guardian acted appropriately in supporting the recommendation that Complainant L return to live with Persons I and F, despite the allegations against Person I.

However, as the case progressed, the guardian should have done more to provide the court with information about Complainant L, including their vulnerabilities and welfare. The guardian should have raised her concerns about Person I's relationship with Complainant L earlier than was the case. This would have allowed the court to have made a fully informed decision about what was best for Complainant L.

The guardian did not comply with Cafcass's record keeping policy. They did not ensure their records were a clear, transparent and accessible record for the child and family in the future. Cafcass's claim that some of the records were illegible was not open and transparent, as we were able to read them and make our own transcripts.

Cafcass's supervision of the guardian was lacking. The supervision was not frequent enough and was mostly factual. The supervision was poorly recorded, and the records were not properly maintained. This was not in line with Cafcass's policy.

Cafcass did not handle Complainant W's Subject Access Request (SAR) effectively. It unreasonably decided to stop communicating with Complainant W about the SAR. It did not release all records Complainant W was entitled to. Part of the reason for this was the poor record keeping by the guardian. The record keeping by the guardian and the management of the records, including transcription of the guardian's notes, was so poor it led to Complainant W believing records had been wrongly destroyed or withheld.

We also found that Cafcass did not handle the complaint fairly or objectively and was not open and transparent in its decision making.

Putting things right

The record management failings we found in this case were so significant and widespread that they had a clear emotional impact on Complainants W and L, contributing to their uncertainty about what happened, and the amount of time they had to spend in pursuing answers to their questions. This continued for many years.

We recommended that:

- Cafcass's chief executive write to Complainants W and L to apologise for the failings we identified
- Cafcass pay Complainant L £6,000
- Cafcass pay Complainant W £2,000

Cafcass outlined to us how, since the time of the issues in the complaint and the time it spent investigating L and D's concerns, it has significantly improved its record keeping,

management of Subject Access Requests and supervision of guardians. For this reason, we did not recommend any service improvements.

Cafcass complied with our recommendations.



British Embassy failed to support and protect a person detained overseas.

Organisation: Foreign and Commonwealth Office

The complaint

Complainant R complained that a British Embassy did not do enough to support them when detained abroad. They said the Embassy did not visit them at a detention centre and did not follow up concerns for their health and welfare, including after they were injured while in the detention centre.

Complainant R also complained about the lack of communication from the Embassy during their detention. Complainant R said the Embassy did not respond to emails and did not provide enough information about what detainees should expect.

Finally, Complainant R complained the Embassy did not contact the local authorities when he faced being deported.

Background

Complainant R contacted the British Embassy after being detained while trying to leave the foreign country they were living in. Embassy staff spoke to Complainant R to understand their situation and provided a Prisoner Pack. Embassy staff sought to make sure Complainant R would be safe after Complainant R reported threats from other detainees.

A few days later, a friend of Complainant R contacted the Embassy to tell staff that Complainant R had been transferred to a different detention centre and had fallen ill. Staff visited Complainant R in hospital, finding them cuffed to a bed by an ankle. Records show that Complainant R reported mistreatment.

Complainant R was moved to a police station away from other detainees. Complainant R made further reports of mistreatment by the police. Complainant R was later transferred to a prison. Embassy staff visited Complainant R when they raised further concerns about the conditions in detention.

The next month, the Embassy raised the allegations of mistreatment with local authorities. There was also a riot at the prison Complainant R was being held, during which they were shot in the eye with a rubber bullet. Complainant R's family asked the Embassy to seek medical attention for Complainant R.

Over the next two months, the Embassy continued to seek medical attention for Complainant R. Local authorities provided a response to the allegations of mistreatment. Embassy staff visited Complainant R twice, noting they were still waiting for medical treatment. Two months later, Complainant R was still waiting for treatment. They then wrote to the Embassy to complain it had failed to represent and protect them.

Over the following months, Complainant R continued to communicate with the Embassy and received occasional visits. They were deported later that year.

What we found

The Embassy failed to respond adequately to Complainant R's reports of mistreatment. The Embassy did not raise concerns with local authorities for two months and did nothing further when Complainant R told staff they were not happy with the local authorities' response. The Embassy did not follow Foreign and Commonwealth Office (FCO) guidance, which includes the requirement that Embassy staff take follow-up action if they receive unsatisfactory responses.

The Embassy also failed to respond to a letter Complainant R wrote to the Ambassador, which was in part a request for exceptional

levels of support, beyond which the Embassy would usually provide. The Embassy did not reply to Complainant R for seven months, and this reply was not actually a response to the initial letter and did not respond to all the issues they raised. The Embassy was not 'customer focused', as all public services should be. This is set out in the Ombudsman's [Principles of Good Administration](#).

Complainant R was held at a police station for over a month. Embassy staff had visited them immediately before this transfer to the police station and were aware both of Complainant R's condition and their concerns about mistreatment. Yet staff did not visit them at all during this time. This did not follow FCO guidance and advice on how often staff should visit people detained, particularly in circumstances such as those reported by Complainant R.

Complainant R had repeatedly reported mistreatment to the Embassy, and staff were also aware of his poor health and welfare. There was a lack of action taken to respond to this and make representations to local authorities. Staff did not act when Complainant R was cuffed to a bed to understand why the local authorities used this restraint, and they should have done more to ensure he had a bed when in prison.

The Prisoner Pack the Embassy gave Complainant R did not accurately reflect conditions in the prisons and other detention centres they were held in. This information should have been updated more frequently to reflect the conditions at the time.

The Embassy also did not consider contacting immigration authorities in relation to Complainant R's impending deportation, although Complainant R had made it clear they wished to stay in the country.

Putting it right

Complainant R suffered mistreatment during his detention, which took its toll on their physical and mental health. The lack of support from the Embassy contributed to their feelings of isolation and stress. Although we could not say whether, had the Embassy done more, the conditions Complainant R was held in would have improved, we recommended the FCO:

- Write to Complainant R to apologise for the impact of the failings we found and explain what it had done to prevent a repeat
- Consider what it could do to recover their belongings
- Update the Prisoner Pack
- Make a payment of £2,950.

FCO has complied with our recommendations.



Poor communication and delays left people not knowing whether they could drive

In 2016, we published [Driven to Despair: how drivers have been let down by the Driver and Vehicle Licensing Agency](#). This report covered eight complaints about the Drivers Medical Group (DMG), the part of the Driver and Vehicle Licensing Agency (DVLA) that considers whether people with a medical condition are safe to drive. The complaints presented in the report covered decisions made by DMG between 2009 and 2014.

The complaints in *Driven to Despair* were about delays by DMG in making licensing decisions, poor communication, the quality of the information provided, and poor complaint handling. Following this report, the Public Administration and Constitutional Affairs Committee (PACAC) launched an inquiry into the issues we identified. This inquiry was interrupted by the 2017 General Election and PACAC was unable to issue a final report after taking evidence. As a result, the Government has not been required to respond to any findings from the inquiry.

The complaints below cover events from 2013 to 2017. Some of the events complained about occurred after the *Driven to Despair* was published. We therefore highlight this issue again in case any Parliamentary Committee wishes to revisit our original findings to ensure that appropriate lessons have been learned.

Organisation: Driver and Vehicle Licensing Agency

The complaints

Complainant M complained that it took DVLA too long to reach a decision about issuing them with a driving licence and did not consider the advice of Complainant M's doctors, who suggested that their licence should be reinstated. Complainant M also said that DVLA

did not allow them to undertake a driving assessment.

Complainant B complained that during the process of reapplying for their licence, DVLA contacted the wrong consultant, did not obtain consent before contacting the consultant, and offered them a driving assessment when its outcome would have made no difference.

Both complainants told us that being without their licence had a great impact on their lives. Complainant M said that having to wait such a long time for a decision added to their distress. Complainant B said that the process caused them additional stress on top of their illness.

Background

Complainant M had a condition which caused severe pain. Complainant M's GP contacted the DVLA to inform it that they were taking diamorphine (a very strong painkiller) for their condition. DVLA revoked Complainant M's licence as they were unfit to drive at this time.

Complainant M provided information which stated that although they were on a high dose of opiates, this did not cause any side effects. They applied for their licence, which DVLA refused. Complainant M appealed that decision, but the Magistrate's Court dismissed their appeal and DVLA again refused to issue them with a licence.

Complainant M's new GP and pain management consultant wrote to DVLA to say they were fit to drive. DVLA referred the issue to a medical panel for expert advice. This process was taking too long and Complainant M complained to the Independent Complaints Assessor (ICA — the second-tier complaints handler for complaints about Department for Transport's agencies), who wrote to them and acknowledged that DVLA was taking too long to decide. DVLA then wrote to Complainant M and said it would not issue them with a driving licence.

Complainant B was diagnosed with lung cancer and an asymptomatic brain tumour. Complainant B stopped driving and surrendered their driving licence when they started treatment. They reapplied for their licence three months after completing treatment.

DVLA refused Complainant B's application based on guidance which stated that a person should wait at least a year after completing treatment to be able to drive. Five months later, Complainant B's consultant in palliative medicine told DVLA that Complainant B never had any symptoms from their brain tumour. DVLA decided that Complainant B could reapply for their driving licence and Complainant B provided the relevant forms including consent for DVLA to contact their specialists. After contacting the palliative consultant again, DVLA issued Complainant B with a licence valid for one year.

What we found

DVLA referred Complainant M's case to panel for expert advice, in line with available guidance. However, DVLA took 11 months to reach a decision after Complainant M provided new information. This was far longer than the 90 working-day service standard the DVLA set for itself for 90% of its medical cases.

During this time, Complainant M, their solicitors and MP were chasing a response from DVLA. We found that DVLA did not give them a clear understanding of the process of applying to panel for advice, how long it might take or how many panel members were providing reports.

We were not able to understand why DVLA requested the advice of two panel members but only one was received and considered. This was because DVLA failed to retain any records which would evidence the reasons for its decision. Complainant M was therefore left with little information about the panel process and had to wait several months to find out DVLA's decision.

We did not find that DVLA should have followed the advice of Complainant M's doctors as DVLA is legally responsible for deciding if a person is medically unfit to drive, and this decision is at DVLA's discretion. We also did not find that DVLA should have allowed Complainant M to undertake a driving assessment since they could not satisfy the requirements for safe licensing.

In Complainant B's case, the DVLA eventually issued them with a driving licence. We did not find that DVLA had contacted the wrong consultant or that it did so without obtaining Complainant B's consent, as they had provided a form with written consent.

However, DVLA's communication with Complainant B was not open and accountable. It did not explain to Complainant B why it contacted a different consultant to the one they indicated on their application form and did not clearly explain that a driving assessment would not help with their application for a driving licence. Moreover, on one occasion when Complainant B called DVLA to check the progress of the case, the person they spoke to was not able to access information about the case because the notes were unclear, leaving Complainant B uncertain about the actions DVLA was taking.

Putting it right

We recommended that DVLA should acknowledge its failings and apologise to Complainants M and B. We also recommended that DVLA should make a payment of £200 to Complainant B and £250 to Complainant M in recognition of the uncertainty and distress they suffered because of DVLA's failings.

Complainant M also highlighted that many of the issues that have caused problems in their case were highlighted in our report *Driven to Despair*. In particular, the lack of transparency about the process followed and how cases are assessed by panel, as well as failures in record keeping and accountability.

DVLA told us that it has introduced a new system to try to ensure panel referrals are treated in a timely manner and we welcomed these changes. We also recommended that DVLA should review learning from this complaint and ensure that there is enough information available to applicants about the process of applying to panel, as well ensuring that there is adequate record keeping of referrals to panel and communication with panel members.

DVLA complied with our recommendations.



Family suffered prolonged nuisance and stress after Environment Agency failed to take enforcement action against landfill site

Organisation: Environment Agency

The complaint

Complainants J and B complained that the Environment Agency (EA) has repeatedly failed to enforce environment control permits issued to a landfill site. Complainants J and B said that they experienced odours, noise, litter, dust and vermin, amongst other disruption. They said that Complainant B suffered an illness as a direct result of toxins produced at the site. They also said their house had been devalued by approximately £150,000.

Background

Complainants J and B's house borders the boundary of the landfill site. They had bought their house before the site was used as a landfill, but the site had existing planning permission for use as landfill. The landfill site is operated by a private company. The site was sectioned into cells, which were capped when full.

EA is responsible for ensuring the company meets its responsibilities through environment permits. The primary purpose of the permits is to control and regulate pollution and emissions arising from landfill operations. When EA visits a site, it records findings in a Compliance Assessment Report. If it observes a breach, it records the site as being non-compliant.

Complainants J and B began raising concerns with EA a year after the site opened. They raised their first formal complaint four years later, and their complaints to EA were ongoing until they sold their home a further four years later.

What we found

Complainants J and B complained to the EA about a range of issues that fell within its responsibility as the regulator and issuer of environment permits, including the overfilling of waste cells, the gas management system, odour, noise, litter and bird control.

The landfill site performed poorly for much of the nineyear period complained about. EA's role was to ensure the site complied with the permits it had issued. EA took appropriate action to ensure a gas management system, but this was delayed because the operator was following the appeals process.

We found that EA had asked the operator to undertake a survey of one of the waste cells to see whether it had been overfilled. The operator did not do this. EA did not take any enforcement action for two years. EA told Complainants J and B that there was no evidence of overfilling, despite its own evidence and action two years earlier.

EA was not customer-focused in its initial contact with Complainants J and B. The first proactive contact with residents, including the complainants, was four years after the site opened. EA also did not do enough to monitor the complaints that were made directly to the site operator during the first four years of operation, so it did not have a clear idea of how many complaints had been made about the site.

We saw that EA increased its compliance and enforcement action against the operator after the site had been in use for seven years. However, it did not do enough in the years before, given the large number of complaints about the site. EA did not escalate enforcement action, even when it became clear there were repeated breaches of the permit.

Complainants J and B suffered nuisance and stress over a prolonged period. Had EA acted quicker and more forcefully, the impact on them would have been reduced. However, we did not find that EA's failings caused Complainant B's health issues or that it was responsible for the selling price of their house.

Putting it right

We recommended EA apologise to Complainants J and B and pay them £6,000 in recognition of the impact its failings had on them.

We recognised EA had revised its processes and guidance to deal with noncompliance with permits. However, we recommended it review its procedures and policies for monitoring complaints to site operators and its engagement with the public and residents.

EA have complied with our recommendations.



Ofgem reviewed its earlier decision to claim back £20,000 after a mistake in paperwork by renewable heat supplier

As well as investigating complaints about failings by public service organisations, we do a lot of work outside the investigation phase of our work. This case is an example of one of the many ways we can resolve a complaint and achieve a positive outcome for someone without having to launch a formal investigation.

When we first looked at the details of this complaint, it became apparent to us that there was a clear mistake, as well as an obvious way to put things right. We spoke to the organisation and explained our initial thoughts. Following this discussion, the organisation agreed to look at the complaint again, and ultimately agreed to settle in favour of the complainant.

Organisation: Ofgem

The complaint

Complainant K complained about Ofgem's decision to seek repayment of Domestic Renewable Heat Incentive payments, amounting to nearly £20,000, after a paperwork error by the supplier of the equipment.

Background

In summer 2014, Complainant K sought to replace an old oil-fired boiler with a biomass wood pellet boiler, as part of the government's Domestic Renewable Heat Incentive (Domestic RHI).

The Domestic RHI is a government scheme to encourage the take up of renewable heat

sources when replacing old boilers. People who join the scheme agree to follow a set of rules and then receive quarterly payments in return for the renewable heat their system has produced.

Complainant K's new boiler was installed and commissioned in September 2014 by an approved supplier.

In 2018, Ofgem carried out an audit. Following this, Ofgem told Complainant K that the boiler model installed did not match the model on the paperwork, and the boiler was not approved under the Domestic RHI scheme at the time of installation.

Complainant K queried this with the supplier. The supplier realised that there had been errors on the original submission paperwork, including the date of commissioning and model of the boiler. The corrected details meant that the boiler installed was approved under the Domestic RHI at the time of commissioning. The supplier applied to the Microgeneration Certification Scheme (MCS) to amend the original paperwork. Complainant K appealed to Ofgem.

Ofgem reviewed the case and upheld its original decision and required Complainant K to repay £19,576.12 they had received under the Domestic RHI since the boiler had been commissioned.

What we did

We reviewed Complainant K's complaint. We explained to Ofgem that, while we could launch a full investigation, it seemed there had been a clear administrative mistake by the supplier of Complainant K's boiler, which it had since put right. We said that Ofgem's response to Complainant K's appeal seemed unfair in

these circumstances. We asked Ofgem to review Complainant K's case again.

Ofgem agreed to this. As a result, it agreed to accept the updated paperwork from Complainant K's supplier and to restore them to the Domestic RHI scheme. Complainant K is no longer required to repay any money and will continue to receive appropriate payments, receiving the outcome they desired much more quickly than if we had carried out a full investigation.



Complaints about the NHS in England

Complaints about the NHS make up almost 80% of our work. It is not surprising that we get so many more complaints about healthcare than about other public services given we will all use the NHS throughout our lives.

We see complaints about the full range of NHS services and settings, including GPs, dentists, hospitals, mental health services, and commissioning and funding healthcare. The impact of a mistake by any health provider can be devastating and compounds what is already a difficult time.

The complaints in this report are a snapshot of the investigations we concluded in 2019. This does not indicate that the complaints are from a specific time. It might have taken some time for the complaint to come to us, and the time it takes us to investigate varies. For the most complex cases, we often collect hundreds of pieces of evidence, seek specialist advice, and carefully weigh up a large amount of information.

The cases in this report show the impact of mistakes and the potential for complaints to help drive improvements in the quality and safety of NHS services. We know that many NHS organisations already use feedback from patients and their families to improve NHS services. Unfortunately, this is not the case across the NHS. We hope the cases we have included encourage the NHS and its constituent parts to continuously improve services.

We publish a quarterly report about our health casework, which details the types of complaints we see. You can find these on our website: www.ombudsman.org.uk/publications/reports-about-nhs.



Delayed diagnosis of HIV resulted in pneumonia and increased risk of other illnesses

Organisation: a GP Practice in Merseyside

The complaint

Complainant S complained that the GP Practice missed opportunities to test for human immunodeficiency virus (HIV), resulting in a two-and-a-half-year delay in diagnosis. Complainant S said that the delay denied them the chance to treat their condition at an early stage, which has impacted on their general health.

Background

Complainant S attended the GP Practice on two separate occasions with shingles. The GP Practice did not refer Complainant S for any immune system checks.

Two and a half years later, Complainant S went to the GP Practice feeling very unwell. The GP Practice told Complainant S to go to A&E. Complainant S was found to have pneumonia and hospital staff carried out immune system tests. Complainant S was then diagnosed with stage 4 HIV.

What we found

Complainant S was not known to have any problems with their immune system. They attended the GP Practice on two separate occasions, in quick succession, with shingles. The relevant guidelines say that GPs should refer or seek specialist advice if a person with no immune system problems has two episodes of shingles. This did not happen.

Two and a half years later, Complainant S was diagnosed with stage 4 HIV after becoming unwell with pneumonia. HIV has an incubation period of 10 to 15 years to reach stage 4 after

the virus has been contracted. We found that it was more likely than not that Complainant S had HIV when they were seen for shingles.

The sooner a person is diagnosed with HIV, the better the outcome in terms of life expectancy and quality of life. Following diagnosis, Complainant S's HIV is now at undetectable levels. However, it took a year to reach this level when it would normally take six months. Furthermore, Complainant S continues to have a CD4 count below 200. CD4 are the types of cell that HIV kills. Complainant S's low CD4 count means they are at increased risk of some illnesses, such as pneumonia.

We found the delay in diagnosing HIV means that Complainant S is at significantly higher risk of contracting pneumonia and has an increased risk of other illnesses in future.

Putting it right

We recognised the GP Practice had undertaken HIV awareness training as a result of the complaint. However, it had not put things right for Complainant S. We recommended the GP Practice pay them £2,000 in recognition of the missed opportunity for an earlier diagnosis of HIV, the avoidable contraction of pneumonia and the ongoing distress and worry Complainant S has for their future health.

The GP Practice complied with our recommendations.

Trust caused pain and fever by prescribing HIV treatment without testing for sensitivity

Organisation: Solent NHS Trust

The complaint

Complainant O complained about the care and treatment they received at the Trust for HIV and neurosyphilis (an infection of the brain and the spinal cord). Complainant O told us they suffered a severe adverse reaction to the combination of their antiretroviral medication and penicillin injections.

Complainant O said the failing by the Trust meant the neurosyphilis and pain symptoms were not addressed. They believe this led to a serious deterioration in their health and they now have difficulties walking and speaking, impaired hearing and sight, and double incontinence.

Background

Complainant O attended the sexual health clinic and complained of dysuria (painful or difficult urination) and sores on their buttocks and groin. The genitourinary medicine (GUM) team tested Complainant O for a range of sexually transmitted infections. A nurse in the GUM team told Complainant O that the test results indicated they were HIV positive. A consultant saw them and noted a range of neurological symptoms and arranged for a further review. The consultant documented that Complainant O's antiretroviral treatment (medication to treat HIV) would start the following week. Complainant O's treatment included the antiretroviral (ARV) drug abacavir.

A week later, the Trust suspected Complainant O had neurosyphilis and started giving them a 17-day course of procaine penicillin injections for this. Staff advised Complainant O to continue with their treatment for HIV. The Trust carried out an HLA B*5701 test, which

detects whether someone is hypersensitive to abacavir. The results of that test were not available until 16 days later.

Complainant O returned for injections over the next 10 days. They told the GUM team they had pain in their legs. The following day, Complainant O went to hospital at a different trust with pain, fever and diarrhoea. The medical team at the other trust stopped the injections and prescribed a different antibiotic. The other trust carried out an HLA-B*5701 test and found that Complainant O had suffered a hypersensitivity reaction to abacavir. It advised the medical team to stop antiretroviral treatment.

Complainant O returned to the first Trust and complained of pain in their legs and back. The consultant advised Complainant O to see their GP and told them to restart antiretroviral treatment but avoid abacavir. The consultant saw Complainant O again a month later. Complainant O reported bowel incontinence, difficulty passing urine and continued neurological symptoms. The consultant wrote to Complainant O's GP the following day and recommended a referral to a neurologist. Complainant O had further appointments and four months later was diagnosed with neurosyphilis.

What we found

The Trust should not have prescribed the antiretroviral medication abacavir without carrying out blood tests to see whether a patient is hypersensitive to the medication.

The Trust did not follow the guidelines for diagnosing and treating neurosyphilis. The Trust made the diagnosis without any input from a neurologist and did not carry out a CT scan as it should have done. The Trust should have carried out a more extensive neurological assessment and investigation before beginning treatment, as outlined in management guidelines.

Complainant O had several appointments with the Trust where staff seemingly did not recognise their worsening symptoms. Complainant O's clinical records show that they contacted the Trust several times about deteriorating symptoms for reassurance and assistance. However, staff advised Complainant O to carry on with treatment, and did not offer them a review or a referral to a neurologist. The Trust should have recognised that Complainant O's symptoms were acute (needing immediate attention).

Complainant O suffered from hypersensitivity to treatment containing abacavir, which also worsened the symptoms of neurosyphilis. Their condition got worse during the time that they received this medication and they experienced severe pain, sudden deafness, diarrhoea, muscle spasm and fever.

These failings led to a serious deterioration in Complainant O's health. Had the Trust performed the correct test before prescribing abacavir, it would not have prescribed it and Complainant O would not have experienced these symptoms.

Putting it right

We recommended that the Trust write to Complainant O and apologise for the impact of these failings on them and explain what learning it has taken from this complaint. It should take steps to ensure that these failings are not repeated in the future. We also recommended that the Trust should pay Complainant O £5,000 in recognition of the injustice they suffered.

The Trust complied with our recommendations.



Trust missed two opportunities to diagnose cervical cancer, leading to an unnecessary hysterectomy

Organisation: The Newcastle Upon Tyne Hospitals NHS Foundation Trust

The complaint

Complainant P complained that they received two false negative results following cervical cancer screening (smear tests) before going on to develop cervical cancer. They also complained that the Trust took too long to respond to her complaint.

Background

Complainant P had three smear tests, four years apart. The Trust reported these as negative, meaning that there were no abnormalities that would prompt further investigation.

Complainant P was then diagnosed with cervical cancer after a positive smear test. As a result, they had a hysterectomy.

The Trust later completed an audit of Complainant P's two smear test results before the positive result, as part of the National Cervical Screening Audit. The audit found both test results showed abnormalities in the cells.

Complainant P complained to the Trust. The Trust sought information from another organisation.

What we found

The Trust accepted that the smear tests were reported incorrectly. The Trust said that if these tests had been reported correctly, Complainant P would have been referred for further investigations. However, the Trust had not considered the impact of these failings on Complainant P in its response to their complaint.

We found that if Complainant P had been referred for further investigations following the first wrongly reported test, the cancer would probably have been picked up within 18 months. Treatment at that stage would have been much less intensive, and they would have been continually monitored for 10 years.

We also found that if the second wrongly reported result had been reported correctly, further investigation would have identified a pre-cancerous area or early invasive cancer. Treatment at this stage would also have been much less intensive and Complainant P would have been unlikely to need a hysterectomy.

We found the Trust did not keep Complainant P updated following their complaint. It could have given at least a partial response while it waited for the other organisation to provide additional information. This compounded the distress Complainant P experienced.

Putting it right

We recommended the Trust write to Complainant P to acknowledge and apologise for the failings in reporting of the smear tests and in how it handled the complaint.

The Trust told us the process for reporting smear test results had changed since the events in this case. All tests are now checked by two people and both checks are documented. We were satisfied this reduced the risk of the same mistakes occurring in future.

We recommended the Trust develop a plan to ensure complaints are responded to promptly and complainants are kept updated.

We did not recommend a financial recommendation in this case, as NHS Resolution was involved and was discussing an appropriate financial remedy.

The Trust complied with our recommendations.

Delays in prostate cancer treatment decreased quality of life

Organisation: Lancashire Teaching Hospitals NHS Foundation Trust

The complaint

Complainant A complained on behalf of Person P about the failure of the Trust to diagnose Person P's prostate cancer. Complainant A said that Person P had complained of symptoms typical of prostate cancer and had even asked for a prostate biopsy, but the Trust ignored them and gave repeated courses of antibiotics that did not work.

Background

Person P saw a urology consultant (the Consultant) several times. The Trust first gave Person P medication to treat an enlarged prostate and then antibiotics to treat prostatitis (infection of the prostate). The Trust carried out diagnostic tests, including a cystoscopy (a procedure to look inside the bladder) and a kidney scan. The results of these tests were normal. Person P saw the consultant again when the antibiotics did not work but the Trust discharged them.

Person P's GP arranged for a PSA test (a blood test that measures the amount of prostate specific antigen (PSA) in the blood and that can be an indicator for prostate cancer), which was normal.

A year later Person P's GP referred them back to the Trust under the two week referral for cancer as they had raised PSA levels. The Trust gave Person P antibiotics for prostatitis.

The Consultant saw Person P the following month and found their PSA had risen again. The Trust diagnosed prostatitis, although a semen culture was negative, and the previous course of antibiotics had failed to work. Ten weeks later, when Person P saw the Consultant again, and their PSA had risen even further.

The Consultant wrote to the GP to inform them that the Trust would arrange an MRI and bone scan within two weeks. The Consultant also said they would see Person P again within four weeks. The Trust carried out a prostate biopsy seven weeks later which confirmed that Person P had advanced prostate cancer.

What we found

It was reasonable for the Trust to diagnose Person P with prostatitis when it first saw them, as they did not have significantly elevated PSA and their symptoms were in line with the guidance on diagnosing prostatitis.

However, it was not reasonable to continue with this diagnosis when Person P's PSA was high and other tests to diagnose prostatitis were negative.

NHS target cancer waiting times say that patients should not wait longer than 62 days (two months) from referral to first definitive treatment. To meet that target, all investigations should have been arranged as promptly as possible. We found that this did happen within the target and that there was no evidence of any urgency in making a diagnosis. We found that in total, Person P waited eight months, rather than two, for their first definitive treatment — a delay of six months. The Trust did not carry out appropriate investigations to exclude the possibility of prostate cancer at the right time.

There was a delay of six months in diagnosing them with cancer.

Given the significant link between early diagnosis and treatment and improved outcomes (in terms of survival rates or reducing symptoms), we found that Person P had a reduced quality of life and that the length of their life is likely to have been affected. There was also a lost opportunity to give Person P the best chance of a cure. Person P said that they are upset at the treatment they received and the likely effect this had on their illness.

Complainant A told us that they have also been caused significant upset.

Putting it right

We recommended that the Trust should ensure that the Consultant works with their clinical supervisor to ensure that their practice is in line with current guidance and research in relation to diagnosing prostate cancer. The Trust should also write to Person P and Complainant F to inform them that this has taken place.

We also recommended that the Trust should pay Person P £5,000 in recognition of the injustice suffered and write a letter of apology to them and Complainant A

The Trust complied with our recommendations.

Trust failed to offer combined chemotherapy, resulting in distress and need to travel long distance for treatment

Organisation: Northern Lincolnshire and Goole NHS Foundation Trust

The complaint

Complainant E complained about their medical treatment for pancreatic cancer and a disagreement over what treatment the Trust wanted to use to treat Complainant E's cancer. Complainant E said that the Trust would not provide a combination chemotherapy known as GemCap and recommended using a single treatment known as Capecitabine alone.

Complainant E travelled to another trust, which agreed to provide the GemCap treatment. Complainant E said the events caused them distress and wasted their time, and they felt pressured about the treatment and confused by different clinical options. Complainant E said that travelling to a different hospital for chemotherapy treatment resulted in additional costs.

Background

Complainant E was diagnosed with pancreatic cancer and referred for chemotherapy treatment. Their consultant recommended treatment with the single agent Capecitabine. Complainant E told us that their previous surgeon advised them that dual chemotherapy treatment, GemCap, would be more suitable. GemCap is a combination of chemotherapy drugs Gemcitabine and Capecitabine.

Complainant E queried the treatment available with the consultant during an appointment before they began treatment. Complainant E sought a second opinion at a different NHS trust that was quite far from their home, but which had been recommended in an internet forum about pancreatic cancer. The other trust

offered Complainant E GemCap treatment and they went on to have their treatment at the other trust.

What we found

The Trust should have considered and offered the use of GemCap dual chemotherapy treatment. Although this treatment was not part of the national guidance at the time, this treatment was available at the Trust and Complainant E had been confirmed as a good candidate for dual treatment after their surgery. Moreover, the Trust should have considered the known the benefits of using GemCap rather than Capecitabin alone.

Complainant E was distressed by the events and had no option but to travel to another hospital that offered them the dual treatment. In its complaint response, the Trust did not accept that it should have offered Complainant E this treatment.

Putting it right

We recommended that the Trust send a written apology to Complainant E to acknowledge the impact of the failings we identified in this report. We also recommended that the Trust update its local guidelines to ensure they are up to date. We recommended that the Trust pay £750 to Complainant E in recognition of the distress and upset caused.

The Trust complied with our recommendations.

Failure to react to signs of sepsis meant opportunity to save life was missed

In 2013, we published our [Time to Act](#) report. This covered ten cases in which people had sepsis and clinicians had failed to react in time. Since then, the National Institute for Health and Care Excellence (NICE) has published a national [guideline](#) to help NHS staff recognise and treat this lifethreatening condition more quickly. Public Health England and the UK Sepsis Trust also launched a national sepsis awareness campaign to help parents and carers of young children recognise the symptoms.

More recently, in September 2017, NICE published a new [quality standard](#) setting out priorities for treating cases of sepsis.

The events in this case date back to 2013. We hope all trusts have learned from our earlier report and the new guidelines for treating sepsis with urgency. This case shows once again how vital that is.

Organisation: Barts NHS Foundation Trust

The complaint

Complainant P complained about the care provided by Barts NHS Foundation Trust (the Trust) to their parent, Person U. Person U attended hospital for a colonoscopy, but developed a temperature and their condition deteriorated. Complainant P complained that the Trust did not respond to the deterioration. Person U subsequently died.

Background

Person U went to hospital for a colonoscopy. They had a history of insulin dependent diabetes, anaemia and stroke, which had caused them to need a wheelchair. The colonoscopy was unsuccessful because the

bowel had not been fully cleared. Instead, Person U had a CT pneumocolon (a virtual colonoscopy using X-rays to produce images of the bowel).

Person U was supposed to have been discharged from the hospital after the colonoscopy. On return to the ward, however, they became ill with a high heart rate, low blood pressure and a spike in their temperature. They remained on the ward for two days, before being moved to the adult critical care unit (ACCU) for more intensive treatment. Tragically, Person U did not improve and died five days later. The cause of death was sepsis, relating to 'unspecified gastroenteritis and colitis of infectious origin' (an infection causing inflammation of the intestine and colon).

A member of nursing staff raised concerns with the Trust about Person U's care. The Trust undertook a Serious Incident investigation but did not share the report with Complainant P until four years after it was completed. By the time the complaint was brought to us, the Trust had lost all Person U's paper medical records and most information relevant to the case.

What we found

The Trust failed to escalate and properly manage Person U's condition in the 24 hours after they first became ill. Antibiotics were not provided until 18.5 hours after the first signs of severe sepsis had emerged. Antibiotics should be given within one hour.

This delay meant that Person U's chance of survival was reduced. We could not say that, had treatment been provided at the right time, Person U would have survived. Person U had pre-existing health conditions, which meant that once infection had taken hold, their chances of survival were reduced. However, the long delay compounded that, reducing the chance of survival further.

Furthermore, as the Trust had lost Person U's medical records, we had to rely on the information in the Trust's Serious Incident investigation. The Trust also did not send the Serious Incident report to Complainant P for four years. The failings in Person U's care and the delay in providing explanations to Complainant P contributed to their shock and grief at Person U's death.

Putting it right

We recommended the Trust:

- Write to Complainant P to acknowledge the failings in Person U's care, apologise and explain the learning it had taken from the complaint to improve its service.
- Pay Complainant P £7,500 in recognition of the emotional distress caused by the failings in Person U's care and delay in providing explanations.

The Trust complied with our recommendations.

Failure to carry out echocardiogram led to missed opportunity to provide relevant treatment

Organisation: Gloucestershire Hospitals NHS Foundation Trust

The complaint

Complainant Q complained about the care and treatment provided to Person V, specifically that:

- Doctors wrongly diagnosed emphysema (a chronic lung disease) as the cause of Person V's breathlessness
- The Trust could not provide an echocardiogram at the weekend
- The Trust discharged Person V although they had not had an echocardiogram
- The Trust did not do enough to arrange an urgent echocardiogram once Person V had been discharged
- The Trust had not acknowledged any failings.

Complainant Q said that Person V had a heart attack shortly after being discharged and died. Complainant Q said that Person V was denied the best chance of survival because of failings by the Trust.

Background

Person V, an older person, had experienced breathlessness on exertion for about a month. V then went to stay with Complainant Q and started to experience breathlessness, overheating and nausea. Complainant Q took advice from a GP and Person V was reviewed by a paramedic. They told Person V to go to A&E at the Trust.

Person V was reviewed in A&E. They had

blood tests, and an electrocardiogram, a CT scan and a chest X-ray. The Trust did not have echocardiogram facilities on site. The Trust was able to provide outpatient echocardiogram tests at a different site at the weekend, but the doctor reviewing Person V was unaware of this. Person V was admitted to the acute admissions unit.

Doctors recorded an initial diagnosis of pulmonary oedema (fluid on the lung) as a result of undiagnosed heart valve disease. This was updated to aortic stenosis the following day, followed by community-acquired pneumonia and finally emphysema.

Person V was then discharged, and doctors advised her to seek follow up from their GP. They went back to their own home that day. Person V saw their GP and requested an echocardiogram but was unable to get one as the Trust's discharge letter did not say they needed one.

A few weeks later, Person V had a heart attack. They were taken to their local hospital (run by a different trust). Person V had urgent surgery to replace a heart valve and had a coronary artery bypass but died a few days later.

What we found

The Trust's initial assessment of Person V was in line with the relevant guidelines. Doctors reached the correct diagnoses, based on the information from the tests they carried out.

However, the Trust should have performed an echocardiogram. Guidelines say an echocardiogram should be performed within 48 hours of new, suspected heart failure, which is what Person V's diagnoses amounted to. The Trust should have kept Person V in hospital until the Monday to do the echocardiogram. It was also more urgent to give her an echocardiogram as Person V had been experiencing symptoms for about a month before their admission.

The Trust did not recognise the urgency of Person V's condition. Discharging them without performing an echocardiogram, or at least arranging an urgent echocardiogram, was wrong. The discharge letter to Person V's GP did not convey any urgency in the need to arrange an echocardiogram.

By not performing an echocardiogram, the Trust missed an opportunity to diagnose the extent of Person V's illness and provide relevant treatment. However, we were unable to say whether Person V's tragic outcome could have been prevented.

Putting things right

The Trust demonstrated learning from the complaint and has ensured echocardiogram equipment is available. However, we considered the Trust had not fully acknowledged the extent of its failings.

We recommended the Trust wrote to Complainant Q to acknowledge and apologise for the failings we found. We also recommended the Trust put together an action plan to further improve its service around recognising the urgency of treating aortic stenosis and providing an echocardiogram within 48 hours of admission.

We also recommended the Trust pay Complainant Q £4,000.

The Trust complied with our recommendations.



Doctors took skin graft from inappropriate place and without telling the patient

Organisation: The Queen Victoria Hospital NHS Foundation Trust

The complaint

Complainant G complained about the skin graft operation they had at the Trust. Complainant G complained that the surgeon used skin from the shin as a donor site, when they should have used a less visible area. Complainant G also complained that there were no discussions before the skin graft about the suitability of the shin as a donor site, alternative skin graft donor sites or the long-term effects the skin graft would have.

Complainant G told us that they lost the opportunity to decide where the skin would be harvested from for the graft and that they were left with a visible scar on the shin, which has caused them anxiety and distress.

Background

Complainant G fell and cut their leg. The Trust stitched the wound, but it later became infected. Complainant G had dead skin removed from the wound, but it was not possible to close it. The Trust performed a skin graft to resolve the issue, taking the graft from Complainant G's shin.

The Trust's complaint response said that that ideally skin should have been harvested from the thigh area rather than the shin when staff performed the procedure.

What we found

The Trust did not choose a donor site in line with guidance. It should have taken the skin graft from the upper and outer thigh area, where the skin is relatively thick and easy to harvest, and the scar is easier to conceal. The

Trust could have taken skin from the lower leg, but only if it was taken from an area directly next to the wound. The Trust took the skin graft from a different area on the leg.

The Trust did not tell Complainant G that a skin graft was needed, and no discussion took place about the choice of donor site. Complainant G would have chosen a less visible site from which to take the skin graft and has now been left with a permanent scar.

Putting it right

The Trust accepted that Complainant G's skin graft was performed in an unconventional way and that Complainant G is likely to have a permanent residual scar. It also said that learning from this event has been fed back to the surgical team.

We recommended that the Trust should make a payment of £950 in order to acknowledge the impact these failings had on Complainant G.

The Trust complied with our recommendation.

Trust missed insulin dose, leading to diabetic ketoacidosis and heart attack

Organisation: Great Western Hospitals
NHS Foundation Trust

The complaint

Complainant B complained about the care the Trust provided to Person H. Complainant B said that the Trust failed to provide Person H's overnight insulin dose. This led to Person H suffering diabetic ketoacidosis (DKA), which the Trust did not identify or treat in a timely manner. Complainant B told us that they believe that Person H died of complications caused by DKA.

Background

Person H was admitted to the Trust after a fall. They had a history of diabetes and heart disease, as well as a new diagnosis of Parkinson's disease. During this admission, Person H did not receive their night-time insulin injection. Two days later Person H developed DKA, a life-threatening complication, and the Trust provided treatment for this. It appeared that the DKA responded to treatment, but Person H deteriorated further. Person H died two days later from heart failure.

What we found

The Trust did not give Person H their long-acting insulin dose and this led to them suffering from DKA. The Trust said that the handover sheet from one team to the other did not indicate that Person H was on insulin and this was why they did not receive the necessary dose.

Two days after the missed dose, there was a medical review in the morning that raised concerns about Person H's rising blood sugar levels. Four hours later, staff called the emergency team because Person H's condition

had deteriorated. The Trust provided treatment for DKA and it appeared that this had resolved by the afternoon, as Person H's blood sugar levels reduced. We therefore found that the Trust correctly treated Person H's DKA.

The Trust accepted that it missed the insulin dose, but it said it correctly treated the DKA. Person H had a heart attack and the Trust said that this was unrelated to DKA and the missed insulin dose. We found that the stress caused by DKA would have increased the risk of a heart attack, especially in a patient with existing heart disease. It was more likely than not that Person H's DKA contributed to their cardiac event and subsequent death.

It was not possible for us to say with any certainty that Person H would not have had a heart attack even if they had received the missed insulin dose. However, it is more likely than not that the DKA contributed to them having a heart attack. The Trust had not acknowledged this.

The Trust should have recorded this as a Serious Incident, as all cases of hospital acquired DKA should be recorded as a Serious Incident. A root cause analysis should be carried out to investigate why a patient has developed DKA.

Putting it right

We recommended that the Trust acknowledge it made mistakes and apologise to Complainant B for the failings identified and the distress and upset caused to the family. We also recommended that the Trust should prepare an action plan setting out what actions it will take to address the failings we identified.

The Trust complied with our recommendations.

Mental health care

In March 2018, we published [Maintaining Momentum: driving improvements in mental health care](#), highlighting common themes we had seen in complaints about acute mental health services.

Given the commitments currently being delivered in relation to the NHS's Five-Year Forward View for mental health treatment, we did not make systemic recommendations at the time. We continue to shine a spotlight on these types of cases to ensure the NHS learns from mistakes and policy makers and Parliament can consider what more is needed in this area in light of the real experiences of patients.

Mental health trust missed opportunity to prevent a person taking their own life

Organisation: 2gether NHS Foundation Trust; Gloucestershire Hospitals NHS Foundation Trust

The complaint

Complainant C complained about the care provided to Person R in the period immediately before Person R's death.

Specifically, Complainant C complained that 2gether NHS Foundation Trust (the Mental Health Trust) did not carry out regular observations to prevent Person R suffering harm from epileptic seizures or to prevent self-harm. Complainant C said there was a lack of consultant cover, so insufficient action was taken in response to an increase in Person R's seizures. Complainant C also said Person R lost a significant amount of weight, which further impacted on their mental and physical health.

Complainant C complained that

Gloucestershire Hospitals NHS Foundation Trust (the Hospitals Trust) did not follow the care plan it had put together for Person R and sent them back to the mental health ward despite them having a recent seizure. Complainant C also complained that the Hospitals Trust changed Person R's epilepsy medication, which was not appropriate for them.

Complainant C said that Person R's death could have been avoided.

Background

Person R had a history of mental ill health and had previously self-harmed and attempted to take their own life. Person R also suffered epileptic seizures. Person R had a diagnosis of schizophrenia and emotionally unstable personality disorder. The combination of their epilepsy and mental health diagnoses was complicated because the medication for epilepsy can cause depression, while antipsychotic medication can make seizures more likely.

Person R had been a long-term inpatient on a ward at the Mental Health Trust. Immediately before the issues complained about, Person R spent time in the psychiatric intensive care unit (PICU). While in PICU, Person R began having more frequent seizures, and ultimately had seizures almost daily. Staff at PICU added an antipsychotic medication to Person R's prescriptions.

When Person R returned to the ward from PICU, they tried to take their own life on three occasions. Person R also continued to have epileptic seizures. Person R was then taken to the Hospitals Trust (which operates from the same site) while having a seizure that could not be brought under control. They returned to the ward at the Mental Health Trust the same day.

The next day, Person R was again taken to the Hospitals Trust after suffering two seizures.

The Hospitals Trust admitted Person R for a neurology review. Doctors put together a care plan that said Person R should stay on the neurology ward until they had been seizure-free for 48 hours. Person R was returned to the ward at the Mental Health Trust the next day, because they had tried to take their own life while at the Hospitals Trust. Person R had another seizure that night.

The following day, Person R tried to take their own life, but was found by a member of staff.

The next day, Person R again tried to take their own life. They were found and resuscitated but died a few weeks later having never regained consciousness.

What we found

The Mental Health Trust did not manage Person R's risk sufficiently. The documented risks were often contradictory. We did not see evidence that risk assessments took account of Person R's specific circumstances and coping strategies. Furthermore, the risk assessments were not updated following Person R's attempts to take their own life. Observations should have been increased in response to these attempts but were not. This meant that the Mental Health Trust could have prevented Person R's death.

There was poor communication between the two Trusts. In particular, the Trusts missed an opportunity when Person R was moved from the Hospitals Trust back to the Mental Health Trust to properly consider the management of both their physical and mental health.

Although the decision to send Person R back to the Mental Health Trust may have been reasonable, the rationale for this decision was not recorded. There was a lack of information in the records for how staff at the Mental Health Trust should respond to Person R's continued seizures. The handover from the Hospitals Trust to the Mental Health Trust did

not follow the relevant guidance, particularly in respect of Person R's complex needs and the interaction between their epilepsy and antipsychotic medication.

The change to Person R's epilepsy medication while at the Hospitals Trust was not appropriate to manage their worsening seizures, given the impact the seizures were having on Person R's mental health. Alternative drugs should have been considered that could have helped Person R more effectively.

Putting it right

We recommended that the Mental Health Trust and the Hospitals Trust work together to put in place protocols to make sure people referred between them have appropriate handovers. The two Trusts should consider the need for multidisciplinary team working for patients with inter-related mental and physical health needs.

We recommended the Mental Health Trust review the risk assessments and decisions about observations in this case and create an action plan to make sure its processes adhere to relevant national guidance.

We recommended the Hospitals Trust review the management of Person R's epilepsy medication.

We also recommended the Mental Health Trust pay Complainant C £8,500, and the Hospitals Trust pay £1,500.

Both Trusts are due to comply with our recommendations by the end of February 2020.

Misunderstanding of patient choice legislation led to delay in diagnosing and treating PTSD

Organisations: A GP Practice in Suffolk; Ipswich and East Suffolk Clinical Commissioning Group

The complaint

Complainant V complained that their GP Practice and CCG did not allow them to choose the first available outpatient appointment for mental health treatment.

Complainant V also complained that the CCG wrongly interpreted patient choice law when rejecting their Individual Funding Request (IFR — a process for people to apply for special funding for treatment that might otherwise be unavailable) and that neither the CCG nor the Practice sought clarity on the law.

Complainant V also complained about the GP Practice's complaint handling.

Complainant V said this caused a two-year delay in getting treatment from the healthcare provider of their choice, which had a major impact on their mental health. Complainant V also said they had been unable to continue with their career until they received treatment.

Background

Complainant V worked for an NHS mental health trust. Complainant V raised concerns about poor care, after which they experienced bullying from colleagues in management. Complainant V left their job having reached a compromise agreement with the trust.

After this, Complainant V suffered from a deterioration in their mental health, experiencing mild to moderate depression, thoughts of self-harm, paranoia, obsessive behaviour and social withdrawal. Complainant V was also recently diagnosed as being on

the autistic spectrum and having Asperger syndrome.

Complainant V's health declined further. They attended an appointment at their GP Practice, which agreed to refer them to an NHS trust that was not the Trust they had previously worked for. Complainant V was seen at this trust and was referred for treatment through the Improving Access to Psychological Therapies programme. However, this service discharged Complainant V as it was unable to meet their needs. They had a further assessment at the trust. It recommended Complainant V's GP referred them to a private psychiatrist.

The GP Practice submitted an IFR to the CCG seeking funding for a referral to a private psychiatrist.

Complainant V subsequently agreed to a referral to an alternative trust. The CCG rejected the IFR but did not inform Complainant V. Complainant V then asked the GP Practice to refer them again to a private psychiatrist as they had found enough money to pay for one appointment.

The GP Practice contacted the CCG in relation to Complainant V's case, and then made a further IFR. The CCG wrote to the Practice to say they could refer Complainant V to any NHS provider without any need for funding approval.

What we found

Although the GP Practice was trying to help Complainant V, it did not follow the IFR process properly. It did not discuss patient choice or the process for referring to an NHS provider. This contributed to a delay in Complainant V's diagnosis and treatment of PTSD.

The GP Practice also handled the complaint poorly and did not answer all of Complainant V's questions.

The CCG misinterpreted the patient choice legislation and incorrectly told Complainant V about the limitations of patient choice in a mental health setting. This further contributed to the delay in the diagnosis and treatment of Complainant V's PTSD.

Putting it right

We recommended the Practice apologise for the mistakes it made and set out how it has learnt from the complaint. We recommended the Practice pay Complainant V £500.

We also recommended the CCG apologise and set out the learning from the complaint. We also recommended the CCG pay Complainant V £500.

Both the Practice and the CCG have complied with our recommendations.

Trust failed to treat the mental health of a young person with autism

Organisation: Sussex Partnership NHS Foundation Trust

The complaint

Complainant G complained that the Child and Adolescent Mental Health Services (CAMHS) at the Trust did not accept the referral from Person E's GP in a timely manner and then did not provide a diagnosis or treatment for three years. Complainant G also complained that the Trust discharged Person E too soon.

Complainant G complained that the Trust refused to handle the complaint and referred it to another Trust. They also complained about delays in responding to the complaint.

Complainant G said that, as a result, Person E's condition worsened until it reached crisis point. Complainant G said Person E has missed out on three years of education. They told us of concerns they had for Person E's future health and the support they need. Additionally, Complainant G told us of the emotional impact on both Person E and the family.

Background

Person E's GP referred them to the Trust. The Trust refused to accept the referral, as Person E did not meet its criteria.

Six months later, Person E's GP made a second referral. The Trust accepted this referral. Complainant G then reported that Person E was unable to leave the house and would not communicate. The Trust agreed to visit Person E at home. During two home visits, Person E was physically aggressive and would not speak to Trust staff. At a third home visit, Person E spoke to the Trust staff.

At the fourth home visit, Person E again displayed aggression towards Trust staff. The staff recorded that it had not been possible to assess Person E, but they were suffering severe mood instability and extreme distress over trivial issues. Person E later attended the Trust, but again would not engage in assessments.

The Trust then completed a risk assessment for Person E, noting that family members were restraining them to avoid harm to Person E and others.

Person E was then diagnosed with autistic spectrum disorder. Six months later, the Trust sought to discharge Person E from its service. Person E's GP then made a further referral to the Trust, which the Trust considered but did not accept. Person E's GP attempted a further referral to the Trust. The CAMHS service was transferred to another Trust at this time, which continues to care for Person E.

What we found

The Trust did not follow the relevant guidelines when rejecting Person E's first referral. It should have accepted this referral.

It was not appropriate to wait over 18 months for a diagnosis and treatment, despite Person E not communicating with Trust staff during this time. The Trust should have made more attempts to communicate effectively with Person E, such as email and telephone as non-direct methods of communication. The Trust made no attempt to use other methods of communicating with Person E.

Although Person E did not cooperate with Trust staff, their behaviour should not have prevented the Trust trying other ways to engage them. The Trust should have sought advice from other agencies on how to best engage with Person E. When a member of staff left the Trust, it did not reallocate Person E's care to another staff member.

The Trust discharged Person E too early from its service, as they continued to need support for their mental health as well as autism. Person E and the family continued to need support on how best to manage Person E's mental health and wellbeing, which the Trust should have provided. The Trust should have developed a care plan for Person E to outline the support and treatment they needed.

As a result of these failings, the Trust missed the opportunity to help Person E and the family develop the appropriate steps to support her mental health. Person E suffered prolonged mental ill health. Person E and the family were left without the ability to manage Person E's condition at the time.

Putting it right

We recommended the Trust acknowledge the failings in Person E's care and apologise for the impact of this. We recommended that the Trust ensure that CAMHS (which had been taken over by a different Trust) learns the lessons from the failings we identified.

We recommended the Trust pay Person E £1,500 for the impact the lack of treatment had on them. We also recommended the Trust pay Complainant G and the family £500 for the distress they experienced.

The Trust complied with our recommendations.

Trust prescribed wrong anti-psychotic medication, resulting in significant impact on mental health

Organisation: Sussex Partnership NHS Foundation Trust

The complaint

Complainant T complained about the Trust giving them wrong anti-psychotic medication. Complainant T said that their mental health dramatically deteriorated as a result of the Trust given them the wrong medication. Complainant T experienced paranoia, became aggressive and tried to take their own life.

Background

Complainant T had a diagnosis of schizophrenia and had been receiving injections of Depixol, an anti-psychotic medicine, for over two decades. When Complainant T saw their psychiatrist, the psychiatrist decided to change the frequency of their Depixol injection. However, the psychiatrist mistakenly prescribed Clopixol and the Trust injected them with Clopixol two times in four weeks. In the month after the second injection, Complainant T tried to take their own life and was detained under section 2 of the Mental Health Act for three weeks.

What we found

When the psychiatrist decided to change the frequency of the Depixol injections, the psychiatrist made an error and prescribed Clopixol instead. Complainant T relapsed with psychosis and experienced paranoia and symptoms of being reclusive. In its complaint response, the Trust confirmed that it prescribed Complainant T incorrect medication that was likely to have contributed to their relapse.

The Trust prescribed this medication in error. Clopixol and Depixol have similar names and are both used to treat schizophrenia. The Trust should have taken care when prescribing this medication. While looking at Complainant T's clinical records, we also found that the Trust had made the same error in a consultation note and in previous prescription.

When the community mental health nurse (CMHN) visited Complainant T for the second injection, the nurse decided to speak to the psychiatrist about the medication Complainant T was taking as the dose was too low. The CMHN did not follow up on this. The Trust did not have a procedure in place to ensure that the correct medication was prescribed and administered.

As a result of the Trust's error, Complainant T's mental health deteriorated. They became paranoid and aggressive and tried to take their own life. Complainant T's relapse was a direct result of giving them the wrong medication.

Putting it right

The Trust had already apologised to Complainant T and said that the error 'likely contributed' to their relapse. It also made service improvements, such as sending patients copies of their letters so they can ensure their medication is correct. However, we did not consider that the Trust remedied the personal injustice that Complainant T experienced.

We therefore recommended that the Trust should apologise to Complainant T and acknowledge the impact these failings had on Complainant T. We also recommended that the Trust should pay Complainant T £1,700 as a recognition of the impact of these failings.

The Trust complied with our recommendations.

Other publications in 2019

We publish quarterly reports that cover complaints about the NHS in England. These reports cover the headline statistics from complaints we have received and completed about the NHS. We are developing these reports over time and increasing the amount of data we publish. In December 2019, we began to publish all the recommendations we have made.

In 2019, these reports have focused on:

- our [work to resolve cases quickly](#), without the need for a full investigation
- examples of [financial remedy](#) and how we use our [severity of injustice scale](#)
- issues experienced by people with [autism and learning disabilities](#) in NHS services, highlighting that we have signed up to NHS England's [Ask Listen Do](#) project.

You can sign up to receive these publications by emailing researchteam@ombudsman.org.uk.

In December 2019, we also began to publish the full [breakdown of complaints we handled about NHS organisations](#) in England, and all the [recommendations](#) we make when we find a failing.

We regularly publish summaries of significant cases throughout the year to highlight failings and encourage learning from mistakes. We have included all the cases we have published in 2019 in this report, which we are highlighting again to Parliament so that relevant Select Committees and MPs are also aware of our findings in these cases.

Baby's death from heart defect was avoidable

Organisation: James Paget University Hospitals NHS Foundation Trust

The complaint

Miss K complained about the care and treatment that her son, Baby K, received at the Trust in November 2015. She said that the Trust failed to act following various checks on Baby K, and it failed to escalate his care in line with the seriousness of his condition and he died as a result.

Miss K also complained about the Trust's handling of her complaint.

Background

Baby K experienced weight loss following gastroenteritis, so his GP referred him to the Trust on 2 November. The GP referral noted that the area of his stomach just below his ribs was drawn inwards, but this was not recorded in his medical records at the Trust. Staff carried out blood and urine tests and an appointment was made with a dietitian for four weeks later.

On 12 November Baby K was taken by ambulance to the emergency department of the Trust after he vomited and became floppy. Trust staff examined Baby K and he was given a Paediatric Early Warning Score (PEWS) of four because he had a fast heart rate and was breathing very fast. A chest X-ray showed that his right lung had changed, and part of his left lung had filled with fluid. Staff suspected that he had sepsis and possibly aspiration pneumonia, which occurs when food or liquid is breathed into the lungs or airway leading to the lungs. Staff gave him oxygen, antibiotics and fluids.

Baby K was transferred to a paediatric ward and his PEWS was increased to five, which meant that his condition was getting worse. An electrocardiogram (ECG), which measures cardiac activity, showed abnormalities including a fast heart rate. Staff observed Baby K hourly and on 13 November, they inserted a tube down his throat to help his breathing. Soon after this, Baby K's heart stopped and staff began cardiopulmonary resuscitation (CRP) which they continued for almost one hour, but Baby K sadly died.

A post-mortem showed that Baby K had a heart abnormality which had caused damage to his heart.

What we found

We found that the Trust failed to:

- act on the results of the ECG and chest X-ray
- consider Baby K's history and symptoms
- ask for input from specialist staff
- escalate his care when his condition was getting worse.

If these failings had not occurred, it is likely that the Trust would have recognised that Baby K had a problem with his heart. In these circumstances, he would have received the correct treatment instead of being treated for suspected pneumonia. We found that on the balance of probabilities, his cardiac arrest would not have occurred, and it is more likely than not that his death would have been avoided.

We also found that the Trust was not open and accountable in its handling of Miss K's complaint, as it failed to acknowledge and apologise for its mistakes in a timely manner. It also failed to signpost Miss K to us at the right time and in the right way.

Putting it right

We recommended that the Trust write to Miss K to acknowledge the failings we identified and apologise for the impact they have had. The Trust should produce an action plan to explain how it will ensure that similar failings do not occur in the future. We also recommended that the Trust pay Miss K £15,000 in recognition of the injustice suffered.

Man not told lung cancer was terminal

Organisation: Royal Cornwall Hospitals NHS Trust

The complaint

Mrs W complained about failings in communication between Royal Cornwall Hospitals Trust and her late husband, Mr W, while he was a patient there.

She said that her husband was not told that an initial X-ray had been misreported and he was left in unreasonable pain until the misdiagnosis was corrected. She also said that the Trust had failed to explain that his lung cancer was incurable.

This meant that Mr W was unable to make an informed decision about his choice of treatment, and he and his family were not given time to put his affairs in order. Mrs W said they were also left without being able to say goodbye properly.

Background

Mr W was referred to the Trust for a chest X-ray on 27 March 2015 after suffering from pneumonia. A separate company, 4Ways Healthcare, reported the X-ray and suggested that Mr W may have had an aneurysm.

Mr W's GP prescribed painkillers in line with this diagnosis. However, symptoms did not improve so Mr W was referred to the Trust again for a CT scan on 16 April.

On 29 April, his GP contacted the Trust to follow up and they found that the X-ray had been reported incorrectly. The results from the CT scan suggested lung cancer. Further tests confirmed this.

The Trust was aware at this point that Mr W's cancer was inoperable.

Mr W began chemotherapy and radiotherapy. However, a further CT scan taken on 30 October showed the cancer had spread and he was admitted to hospital.

He was discharged on 10 November but readmitted on 14 November, as he had significantly deteriorated at home. Sadly, he died later that day.

What we found

We partly upheld this complaint. We did not find that Mr W's GP had acted improperly in managing pain relief. The GP believed Mr W had an aneurysm and started him on lower-scale pain relief with the intention of moving him up as the pain progressed.

We found, however, that the misreported X-ray resulted in Mr W's lung cancer diagnosis being delayed. Had the X-ray been reported correctly, the Trust could have carried out further tests and Mr W could have started palliative treatment sooner.

The Trust should have explained the error in reporting the X-ray to Mr W. It failed to do this, resulting in his family finding out the error after he had died.

We also found there was no evidence the Trust had informed Mr W of his prognosis. As such, he lost the opportunity to make a fully informed decision regarding choice of treatment.

Mr W did not get the time he should have to come to terms with his condition and make appropriate arrangements. His son lost the opportunity to see his father before he died. These failings amounted to a serious injustice to Mr W and his family.

Putting it right

The Trust has apologised to Mrs W and agreed to our recommendations, which are as follows:

- The Trust should agree with 4Ways Healthcare how both organisations will meet duty of candour requirements for patients in their joint care
- It should develop an action plan to address their failure to make Mr W aware of his prognosis and that he was in palliative care.

The action plan should identify the reasons for the failings and explain:

- the learning the Trust has taken from these issues
- what it will do differently in the future
- who is responsible and timescales for each action
- how it will monitor implementation.

The plan should also assure us that no other patients at the Trust are in the same situation as Mr W. That is to say, an error has been made in an X-ray reported by 4Ways that the patient has not been made aware of.

Man died after excessive wait for cancer treatment

Organisation: Warrington and Halton NHS Foundation Trust

The complaint

Mrs Harrison complained about the length of time it took the Trust to operate on her late husband, Mr Harrison's, tumour. She said there was a six-month delay from the Trust diagnosing him with bladder cancer in October 2016 to arranging surgery in April 2017. Sadly, he died in August 2017.

Mrs Harrison says she and her husband suffered extreme anxiety for many months while waiting for the Trust to arrange the operation.

Background

Mr Harrison had symptoms of blood in his urine, so his GP referred him to the Trust on 14 October 2016. On 26 October, the Trust carried out tests and after it found a tumour, Mr Harrison was diagnosed with bladder cancer.

The Trust carried out an endoscopy on 19 December to remove some of the tumour for further testing. The results of the endoscopy were discussed in a meeting on 11 January 2017. The Trust decided to operate on Mr Harrison's cancer on 25 April 2017.

In April, Mr Harrison attended the Trust's emergency department with a swollen leg. The Trust ruled out deep vein thrombosis and the operation went ahead as planned on 25 April. During surgery, it became clear that the disease had spread, and the procedure was abandoned.

Mr Harrison sadly died on 24 August 2017.

What we found

We fully upheld this complaint. We found there were significant delays in the Trust's treatment of Mr Harrison's cancer. He should have been given surgery no later

than 11 February 2017. Waiting until April 2017 significantly exceeded NHS guidelines for the maximum waiting time.

In addition, Mr Harrison went to hospital with a swollen leg in March 2017, but the Trust did not carry out a CT scan. Had a staffed given a CT scan, it would have been shown that Mr Harrison's cancer had spread and become inoperable. Instead, he had surgery in April 2017 after it was too late.

While there is not enough evidence to say his death was avoidable, the Trust's lack of urgency in acting meant that Mr Harrison was not given the best possible chance of survival.

Putting it right

We recommended that the Trust write to Mrs Harrison to acknowledge its failure to treat her husband's cancer promptly enough. It has apologised to her for the uncertainty and distress she is now left with. We also recommended that the Trust should make a payment of £3,000 to her. This figure is not intended to place a value on Mr Harrison's life, but simply to acknowledge the level of anxiety caused as a result of its failings.

The Trust has agreed to develop a system to prevent future failings of the same nature. It should create an action plan to identify reasons for the failings and the learning taken from them. The plan should explain what it will do differently in the future, the timescales in which each action will be completed and how it will monitor staff compliance.

Boy's life put at risk after Trust withdrew specialist care against wishes of family

Organisation: Gloucestershire Care Services NHS Trust

The complaint

Mr A complained about the change in the care package the Trust provided for his son, who has a life-threatening condition and needed nightly ventilation by tracheostomy.

Since Mr A's son's birth, the Trust had a care package in place with fully trained staff who could change the tracheostomy in an emergency. However, this provision was withdrawn.

Background

In 2017 the Trust decided to stop training new staff to carry out this emergency procedure. The Trust informed the family in December that year that parents should either carry out the change themselves in an emergency or call 999.

The family first complained to the Trust in March 2018. They questioned the decision and said the Trust had not provided them with the evidence staff relied on to make it.

They pointed out the suggestion to call 999 was flawed. This is because there is only a window of around twenty minutes before a tracheostomy can no longer be replaced, and the response time for an ambulance is fifteen minutes. The ambulance crew would also not be trained to insert the tube.

The family said there was a lack of clinical evidence to support the decision. They claimed the Trust unfairly dismissed their evidence that their son's life had been put at risk, and the anxiety and distress this caused them.

The family wanted the Trust to reconsider its decision. They believed the Trust should arrange for alternative to give their son the support he needed.

We obtained clinical advice that said that if the overnight carers were not able to undertake the emergency tracheostomy tube change, this would be inappropriate.

The Trust's decision put an additional burden on the family.

What we found

We found that:

- the care provided to Mr A's son fell significantly below good clinical care and treatment
- the Trust fell well short of provision of a suitable and effective service
- there was no indication that the Trust properly consulted the family before making its decision
- the Trust did not act fairly and proportionately in how it carried out its review of this service.

Putting it right

The Trust has already acknowledged some shortcomings, including that it did not look at all available evidence and alternatives when coming to its decision.

Mr A's son's situation has now changed, and he no longer requires this specialist care. However, the family was keen to make sure that the Trust did not repeat its mistakes. Mr A wants to see changes to the Trust's policy and its policymaking procedures.

The Ombudsman recommended that the Trust needed to do more to right these wrongs so that other families do not experience the same failings.

In response, the Trust has written to the family with an apology and an outline of changes it will make. This has been shared with the CQC.

The Ombudsman will continue to review and work with the Trust to make sure it has fully complied with the recommendations.

Surgical error caused unnecessary pain, scarring and avoidable second surgery

Organisation: Manchester University
NHS Foundation Trust

The complaint

Mr T complained about surgery he had at Manchester University NHS Foundation Trust in December 2016.

He said a lipoma, which is a benign tumour, was not removed during surgery as originally planned. As a result, he suffered from nine months of unnecessary pain and scarring and had to undergo an avoidable second operation.

Background

In July 2016, Mr T visited his GP complaining of pain in his back. Following this, his GP sent a letter to the Trust's general surgery department about Mr T needing surgery to remove two lipomas — one from his left leg and one from the left side of his back.

The surgery took place in December 2016 and tissue was removed from Mr T's left leg and back under local anaesthetic. The Trust's surgeon had made an incision below the lipoma on Mr T's back rather than over it as is the usual procedure. The Trust explained that an 'irregular piece of fatty tissue' was removed and histology reports confirmed it was a lipoma.

In February 2017, Mr T visited his GP who told him that the lipoma in his back had not been removed. His GP wrote to the Trust informing them of this and Mr T had a second operation in September 2017 when the lipoma on his back was successfully removed.

What we found

We fully upheld this complaint. We found that on the balance of probability, during the first operation the Trust's surgeon did not make the incision in the correct place on Mr T's back and

did not remove this lipoma. During the second operation, the surgeon made an incision over the lipoma, as is the usual procedure, and successfully removed it. If the incision made below the lipoma during the first operation was in the correct place, this incision would have been reopened. We found no evidence to suggest that the original incision should have been made where it was. This meant that Mr T was left with an additional scar because of an unnecessary operation and this indicated a failing on behalf of the Trust.

Mr T suffered pain from the lipoma while he was waiting for the second operation to have it removed. The Trust said that it was not possible to confirm whether or not his pain was caused by the lipoma remaining in his back or if it was because it had grown back. Our clinical adviser said that, had the lipoma been removed as the Trust claimed, it would not be reasonable for another to grow back in its place so quickly.

Our clinical adviser said the histology report showed that the Trust was not certain that the tissue removed during the first operation was a lipoma.

We found that Mr T suffered avoidable pain from an operation that would not have been necessary if the failing hadn't occurred. Mr T also suffered with avoidable pain for an additional nine months from the lipoma itself, and he has an additional scar on the left side of his body. We also recognised how the failings may have caused Mr T some stress and loss of faith in the NHS.

Putting it right

Following our recommendation, the Trust wrote to acknowledge and formally apologise to Mr T for the failings in his care and treatment. The Trust also paid him £1,000 in recognition of the unnecessary pain and stress caused as a result of the failings identified in our report.

Family of murder victim failed by probation provider

Organisation: Dorset, Devon & Cornwall Community Rehabilitation Company

The complaint

Ms Sarah Compton complained on behalf of her mother, Mrs Michal Taylor, about the victim support service that Dorset, Devon & Cornwall Community Rehabilitation Company (the CRC) provided to them. The service was operated by Working Links at the time.

The complaint was about delays in producing the Victim Summary Report (VSR) Ms Compton and Mrs Taylor were entitled to as set out in the Ministry of Justice's guidelines; unnecessary delays caused by presenting a draft copy to the family and errors made in dating the report. Ms Compton complained that there was poor communication by the CRC and failings in its handling of the complaint: the CRC misunderstood the next stage of the complaint process and incorrectly directed the family to the Prison and Probation Ombudsman (PPO).

Background

When someone on probation commits a serious further offence, such as murder, the probation provider supervising that person must carry out a Serious Further Offence (SFO) review. This review looks at whether or not the probation provider gave adequate supervision. The CRC completed the review in January 2016.

At the same time, the CRC is also required to write a Victim Summary Report (VSR) based on the SFO review. The CRC did not provide a VSR to the family until over a year later, and only after Ms Compton requested one when she was prompted by a third party. She was concerned that she did not know that she was entitled to see the VSR and the CRC failed to provide a reasonable response as to why this happened.

A copy of the VSR was presented to the family at a meeting in June 2017. Ms Compton emailed the CRC to say that she was unhappy with aspects of the report in July 2017 and she requested a hard copy. She did not receive this until November 2017, only to find a number of differences. This was because the June copy was a draft, not a final report. Ms Compton did not receive a reply to nine out of the ten aspects of the report she was concerned about in July until November. Furthermore, the hard copy she received in November was dated March 2017.

What we found

We found that the CRC did not prepare the VSR at the correct time as set out in the Ministry of Justice's guidelines; did not make the VSR available on request; took too long to allow Ms Taylor to view the VSR; caused unnecessary delays by presenting a draft copy to the family; made errors in the dating of the report and communicated poorly by not replying to emails in a reasonable time. We also found that there were failings in its handling of the complaint. The CRC misunderstood the next stage of the complaint process and incorrectly directed the family to the Prison and Probation Ombudsman (PPO).

We found that the failings identified added to Ms Compton and Mrs Taylor's distress at what was already a very difficult and traumatic time for the family.

Putting it right

The CRC had apologised verbally for the delays and incorrect signposting. It took steps to reduce the risk of the failings being repeated.

However, we recommended that the CRC needed to do more to right these wrongs. The CRC should apologise in writing for the failings and acknowledge the impact its failings had on the family. We also said it should provide an updated version of the VSR and take action to address the failings we identified.

Avoidable eye removal surgery after failure to treat infection

Organisation: North Cumbria University Hospitals NHS Trust

The complaint

Mrs F complained that the Trust's poor care and treatment of her husband's eye infection meant that he had to have it removed.

Background

In September 2016 Mr F began experiencing problems with his vision in his left eye. Shortly before his appointment with his GP his vision deteriorated so he visited the GP's out-of-hours service. He was then referred to the Trust's ophthalmology clinic.

He attended the clinic where he had tests to measure his ability to see objects clearly. The test for his left eye measured six out of 12, which is the minimum standard eyesight required for driving. Mr F was given eye drops to treat inflammation. Four days later, the Trust reviewed Mr F's vision again and it had dropped to six out of 24, showing that it had worsened. The Trust advised him to continue using the eye drops.

Mr F's vision in his left eye was measured again in October and it had dropped to six out of 30. He said that his vision in this eye was still blurred so the Trust gave him steroid medication.

The Trust reviewed Mr F's left eye again in November and found that his vision had got worse. The Trust considered arranging for a diagnostic vitrectomy, a surgical procedure to remove some tissue from the eye but decided not to. In December, the Trust advised Mr F to continue taking the same steroid medication.

In January 2017, Mr F attended the Trust and was referred to another trust at his request. This organisation found that his left eye was

severely inflamed because of a fungal infection, and surgically removed it.

What we found

We upheld this complaint. We found that the Trust failed to obtain information about Mr F's medical history. This would have shown that he had been experiencing bladder infections and episodes of urosepsis, where a urinary tract infection spreads to the bloodstream. Based on this and the fact that his eye was inflamed, the Trust should have considered the possibility of an infection.

The Trust did not carry out a diagnostic vitrectomy to find out what was causing the inflammation and sight loss. When it eventually referred him to another trust to carry out this diagnostic surgery, it was too late. The Trust should have done this sooner.

The Trust should not have prescribed steroids to treat Mr F's eye because he had a fungal infection, and these are often made worse by steroids. He was told to continue with this medication for three months, when it was the wrong treatment. This would have been avoided had the vitrectomy been carried out.

The Trust should have changed its approach when Mr F's symptoms got worse. If the correct treatment had been given, while Mr F's vision may have still deteriorated, it is more likely than not that he would have kept his eye.

The care Mr F received from September 2016 to January 2017 was not in line with General Medical Council guidance, which was a failing.

Putting it right

At our recommendation, the Trust wrote to Mrs F to acknowledge and formally apologise for the failings in her husband's care and treatment. It also outlined what changes it has made to prevent this from happening again. The Trust made a payment to Mrs F of £1,000 in recognition of the injustice.

Avoidable death of woman after multiple failings following routine hip operation

Organisation: Doncaster and Bassetlaw Hospitals NHS Foundation Trust

The complaint

Mrs S complained that the Trust did not appropriately diagnose or treat her daughter's infections or recognise that she had developed sepsis, and that her daughter died as a result. Mrs S complained that the Trust did not communicate the sepsis diagnosis to the family.

She also complained that the Trust did not investigate her daughter's case until after she had complained, and that the investigation was unsatisfactory, which meant the Trust could not prevent the same mistakes happening to others.

Background

In October 2015 Miss S was taken by ambulance to the emergency department (ED) of the Trust. She was then transferred to the acute medical unit (AMU), where she was treated for a chest infection and sepsis. Shortly before this, her GP had treated her for a urinary tract infection (UTI) and a chest infection.

On admission to the AMU, Miss S's respiratory rate and oxygen saturation were within the normal range. Her initial assessment and the ambulance record documented pain coming from her abdomen, but staff took no further action. A chest X-ray showed that part of her lung had filled with fluid instead of air, which can indicate a lung infection.

Mrs S told the Trust that her daughter had recently had a UTI and had received treatment from her GP. A urine dipstick test was taken but the results were not recorded or reported to anyone. The Trust reviewed a urine sample

taken by Miss S's GP days before her admission and the results supported the view that the urine infection could be the source of sepsis. Intravenous co-amoxiclav, a broadspectrum antibiotic, was prescribed to primarily treat the chest infection.

An hour after admission, blood tests showed that the level of lactic acid in Miss S's blood was too high. Trust staff measured her urine output and fluids were given, however a blockage prevented them from being given correctly.

Staff did not start recording Miss S's fluids given and passed until she was in the AMU. Staff did not check her lactic acid levels again to see if the treatment had corrected them.

The Trust gave Miss S another antibiotic, gentamicin, to treat the UTI at 1.30pm, which was 15 hours after her admission. While she was waiting to have a CT scan, Miss S suffered a cardiac arrest at 2.10pm and sadly died at 3.48pm on 30 October 2015.

Mrs S complained to the Trust about the care that her daughter had received, and the Trust undertook a Serious Incident investigation.

What we found

We partly upheld this complaint. We found significant failings in the care of Miss S provided by the Trust. She had clear signs of a UTI that were not appropriately responded to.

The antibiotics given to treat the chest infection were assumed to be adequate to also treat the UTI. However, bacteria found in the urine were resistant to the antibiotic given and therefore it was not effective. The more appropriate antibiotic was not prescribed until over 15 hours after Miss S's admission.

When Miss S complained of abdominal pain, good practice should have been to carry out an ultrasound of the abdomen, which would probably have shown further evidence of

the UTI. This would have allowed the correct treatment to be initiated at the earliest opportunity.

The nursing staff in both the ED and AMU missed opportunities to monitor and manage Miss S's fluid input and output and lactate level, and results of a urine dipstick were not recorded or reported to anyone. If the appropriate antibiotics and fluids had been started earlier, the sepsis could have been treated.

We found that the Trust's investigation did not cover all of the issues that were identified or acknowledge that if it had provided the right care and treatment then Miss S's death would have probably been avoided. This caused Mrs S significant distress.

Putting it right

We recommended that the Trust write to Mrs S to acknowledge and apologise for the failings in her daughter's care and treatment.

As this case demonstrates, it is essential that the NHS learns from mistakes and makes sure that sepsis is promptly diagnosed and treated.



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