Parliamentary and Health Service Ombudsman

Selected summaries of investigations by the Parliamentary and Health Service Ombudsman

Volume 1, report 1 (February and March 2014)

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and Health Service
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Contents

Foreword

The Parliamentary and Health Service Ombudsman investigates complaints about government departments and other public organisations and the NHS in England. This volume is the first in a series of quarterly digests of summaries of our investigations. The short, anonymised stories it contains illustrate the profound impact that failures in public services can have on the lives of individuals and their families. The summaries provide examples of the kind of complaints we handle and we hope they will give users of public services confidence that complaining can make a difference.

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

These case summaries will be published on our website in August 2014. For the first time, members of the public and service providers will be able to search a selection of the complaints we have handled by keyword, organisation and location.

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

Dame Julie Mellor, DBE
Parliamentary and Health Service Ombudsman

July 2014

Parliamentary cases

Summary 1/February 2014

Ombudsman asked the court to apologise for error

Mr B complained that a court entered a county court judgment against him in error as it had not followed its procedures correctly. He said it took over a year for the court to remove the judgment from the public record, which had caused him embarrassment and a financial loss.

What happened

A council made a claim against Mr B. The court made a default judgment as Mr B did not respond to the claim. When Mr B applied for the judgment claim to be set aside, the court referred his case to a Residential Property Tribunal. The court removed the judgment sometime later, after the outcome of the tribunal was known.

What we found

The court had in fact followed their procedures correctly. We could not consider if the court had taken too long to remove the judgment as this was due to judicial decisions, which the law does not allow us to look at. The court had not apologised to Mr B about its failure to tell him about a cancelled hearing. It had previously offered to reimburse his travel costs. We also found that the court had destroyed its papers prematurely.

Putting it right

We asked HM Courts & Tribunals Service to apologise to Mr B for not telling him about the cancelled hearing and to review and amend its record keeping policy.

Organisation we investigated

The Ministry of Justice – HM Courts & Tribunals Service (HMCTS)

Summary 2/March 2014

Teenager waited 10 years for a Home Office decision

Separated from his mother after she had to flee her home country, a 17 year old was able to rejoin her after the UK gave her asylum. But he spent all but two weeks of the next 10 years without legal status in the UK, waiting for the Home Office to decide his case.

What happened

The Home Office accepted Mr D's mother as a refugee, giving her permission to stay permanently in the UK. The family reunion policy meant that her children, Mr D and his sister, could join her. Mr D came to the UK later in the year, just before his 18th birthday. He needed to ask the Home Office for fresh permission to stay in the UK after he turned 18 and he applied in time. But the Home Office was unable to accept his forms as a valid application until later in the year, after his 18th birthday. This put Mr D into an administrative limbo. His application travelled with his mother's Home Office file for the next nine and-a-half years. Officials made decisions on citizenship applications from Mr D's mother and his younger sister but continued to overlook his application until his MP sent his case to us. They also overlooked most of his requests for updates.

What we found

The Home Office should have given Mr D a decision much sooner. We decided that, taking all his circumstances into account, it would have given him permission to stay permanently in the UK. The Home Office should also have had a way for staff to put things right when they came across delayed cases like Mr D's. We said that the serious delay limited Mr D to unstable and short-term jobs. He missed out on the support that other 18 year olds could have had and from completing his education as he saw fit. The lack of response to his requests for updates must have been frustrating in its own right.

'I have no documentation to prove that I have any status in the UK ... I am desperate to have my case resolved. It has been 10 years.' Mr D to his MP

Putting it right

The Home Office apologised to Mr D and paid him £7,500 as an apology for the effect of its serious mistakes, particularly the frustration and uncertainty we identified.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 3/March 2014

Man compensated for loss of his job

Mr F, who was exercising EU treaty rights by living and working in the UK, received compensation from UK Visas and Immigration (UKVI) after it caused him to lose his job.

What happened

Mr F obtained a residence card from UKVI that lasted five years. In early May 2012 he applied to UKVI for a permanent residence card. To help applicants to live and work in the UK while their application is being dealt with, UKVI may issue a certificate of application (CoA) confirming this. In mid-May 2012 UKVI stopped issuing CoAs in cases like Mr F's, so he did not receive one.

The next month, UKVI decided to grant Mr F permanent residence. In August 2012 it sent the documentation to the wrong address. In June 2012 Mr F's employer asked UKVI's Employer Checking Service (ECS) for confirmation that Mr F had the right to work. ECS could not see that a CoA had been issued to Mr F or that the decision to grant him a residence card had been sent out. So it told the employer it could not confirm his right to work. The employer sacked Mr F in July 2012. He did not work again until early 2013.

What we found

We upheld Mr F's complaint. Because UKVI no longer issued CoAs in cases such as Mr F's, it was important that it issued the residence card quickly. UKVI did not issue the residence card until August 2012. That was maladministration. When it got Mr F's application, UKVI's computer system defaulted to an out-of date address for him, so he did not receive his residence card until early in 2013. That was also maladministration. As a result, Mr F was unable to prove his right to live and work in the UK.

Putting it right

UKVI apologised to Mr F and compensated him for around £5,500 lost earnings between August 2012 and early 2013.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 4/March 2014

Cafcass was wrong to restrict the complainant's contact with it

Ms S complained about a Cafcass officer's actions. When Cafcass dealt with her complaint, it told her that she should have challenged what the officer had recommended in court. When it did that, it also told Ms S that she was only allowed to contact Cafcass in writing.

What happened

Ms S complained to us about Cafcass. She said that the Cafcass officer who was assigned to her case was biased; that Cafcass allocated her case to the wrong office; that it chose the wrong people to write expert reports; that the Cafcass officer ignored important information, made mistakes, and repeated mistakes that other officers had made; that Cafcass did not follow its complaints procedure correctly; and that it threatened Ms S with its *'vexatious complainant'* policy.

What we found

Cafcass was right to tell Ms S that her dissatisfaction with the Cafcass officer's professional judgment should be raised in court. Cafcass told Ms S that she was a potential vexatious complainant and said that she could no longer speak to them by telephone. This was unreasonable, because Ms S's behaviour was not potentially vexatious. This did not affect Ms S's case, because she was still able to contact Cafcass in writing (including email). We partly upheld the case as a result.

Putting it right

We made no recommendations on this case.

Organisation we investigated

The Ministry of Justice – The Children and Family Court Advisory and Support Service (Cafcass)

Summary 5/March 2014

UK Visas and Immigration apologised for delay on an asylum claim

Poor handling of an asylum case led to a delay of more than two years in Mr R receiving a decision from UKVI.

What happened

When Mr R made further submissions, UKVI was dealing with a backlog of old asylum cases - it called this the '*legacy case backlog*'. Mr R's case fell into this category. UKVI had committed to deal with these cases by July 2011. But it did not deal with Mr R's case until much later.

What we found

UKVI said that the legacy cases were old and complex. But we found that Mr R's case took so long because of UKVI's poor handling. It placed his case in an archive for cases in which it was unable to trace the applicant. It left it there for 18 months even though it heard from Mr R, his representatives, and his MP during this time. After taking the case out of the archive, UKVI still failed to get it right. It incorrectly considered that the case was concluded because it had not logged Mr R's further submissions on its case handling system. UKVI should have concluded Mr R's case much earlier.

Putting it right

While he waited for a decision from UKVI, Mr R was able to live and work in the UK as he had rights of residence under European law. But having to wait so long for UKVI to consider his further submissions caused him uncertainty and anxiety about the likely outcome. We recommended that UKVI apologise to Mr R for this, which it did.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 6/March 2014

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

UK Visas and Immigration delayed making a decision on an application to settle in the UK from an asylum seeker who had lived here for more than six years.

What happened

Mr D sought asylum in the UK in 2004. He was allowed to stay on a temporary basis because of the situation in Iraq. When he had been here for more than six years, he applied for indefinite leave to settle in the UK, as he was entitled to do. But UKVI put his application into an already large backlog of old asylum cases and did not look at it for more than 18 months. It finally granted him leave in August 2013. It also did not respond to letters from Mr D's representatives, who wrote many times to ask what was happening.

What we found

Mr D's application was straightforward. UKVI should not have put his application in the asylum backlog full of difficult and complex cases because it became stuck among these cases. It should have found a more suitable team to deal with his application and, had it done so, there is no reason why it would not have made a decision by early 2012. We also found that its customer service was poor and it failed to update Mr D about his application. As a result, Mr D suffered unnecessary delay, causing him extra levels of stress and uncertainty.

Putting it right

Following our report, UKVI apologised to Mr D and paid him £250 in recognition of the stress, uncertainty and difficulty in finding employment and a place at college that arose from their errors.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 7/ March 2014

Immigration Enforcement to review guidance following Ombudsman's investigation

Poor communication between Immigration Enforcement and its contracted property provider meant that Mr R had great difficulties in having his complaint addressed.

What happened

Mr R was living in a shared room in Immigration Enforcement-funded accommodation while he had an outstanding asylum application. This accommodation was provided by a contracted property provider on Immigration Enforcement's behalf. Mr R was unhappy about his roommate's behaviour and asked for a change of room. Unfortunately, the guidance on who was responsible for dealing with his request was unclear. As a result, Mr R was passed between Immigration Enforcement and the property provider and no one took appropriate action. Mr R did not get a response to his request for a room move for more than a year.

What we found

The conflicting guidance meant that Mr R was placed in a very frustrating situation. He waited far too long to receive a final response to his request to move rooms and to his complaint.

The contracted property provider took too long to handle Mr R's complaint and did not act in line with its complaint procedure.

Putting it right

We recommended that Immigration Enforcement should pay Mr R £500 for stress and inconvenience, apologise, review its guidance and implement systemic changes to make sure that Immigration Enforcement and the property provider are clear about their roles and responsibilities.

Organisation we investigated

The Home Office – Immigration Enforcement

Summary 8/March 2014

Cafcass failed to follow procedures in family court case

A father complained about a Cafcass officer's report to the court in response to his ex-wife's application to emigrate with their children.

What happened

Mr G and his ex-wife (Ms E) have two children. In mid-2012 Ms E applied to the family court for permission to take the children to live with her permanently overseas. The court asked Cafcass for a report. Cafcass Officer A compiled a report and recommended that Ms E's application be granted. Mr G complained that Officer A's report was inaccurate and his professional judgment was flawed. He also complained that Officer A had failed to carry out safeguarding checks on Ms E's family as directed by the court; had not followed Cafcass procedures when completing his report; and was biased toward Ms E. Mr G also complained about Cafcass's handling of his subsequent complaint.

Mr G said that as a result of the failings in the report, he lost confidence in Cafcass and he was unfairly represented by its involvement. Cafcass responded to the complaint and also sent a copy of the complaint to the court.

In August 2013 the court refused Ms E's application to remove the children from the UK and made a shared residence order specifying the time the children would spend with each parent.

What we found

Most of Mr G's concerns about the Cafcass officer's report and professional judgment were addressed by the court. However, the officer failed to follow Cafcass's procedures in some aspects of his report and when responding to directions made by the court. We also found that Cafcass had not responded appropriately when Mr G first complained to it. The failings we identified caused Mr G worry, inconvenience and distress.

Putting it right

Cafcass apologised to Mr G and reviewed the circumstances of his complaint to identify any learning for staff to make sure that they comply with procedures in future.

Organisation we investigated

The Ministry of Justice – The Children and Family Court Advisory and Support Service (Cafcass)

Summary 9/March 2014

Landlord delayed evicting tenant due to HM Courts & Tribunals Service error

A private landlord was unable to start proceedings to evict her tenant because HMCTS did not tell her she had issued them at the wrong court.

What happened

Ms V sent her application to start proceedings to evict her tenant, who had stopped paying rent, to the wrong court. HMCTS should have checked the application when it received it to make sure it was within the jurisdiction of the court. It failed to do so and as a result, a hearing date was set. When the case was heard by the judge, he struck the application out because it had been issued in the wrong court. Ms V had to resubmit her application to the correct court, delaying the start of the proceedings by seven weeks.

What we found

Although Ms V suffered a delay in evicting her tenant as a result of HMCTS' maladministration, she did not suffer a financial injustice. We saw no evidence to suggest that, had the tenant been evicted sooner, she would have paid the rent arrears she owed Ms V. Nor was Ms V in a position to re-let the property for some time, and this was not linked to HMCTS's delay.

Putting it right

HMCTS apologised to Ms V for the delay and paid her £250 to compensate her for this.

Organisation we investigated

The Ministry of Justice – HM Courts & Tribunals Service (HMCTS)

Summary 10/March 2014

The Environment Agency failed to clearly explain its role

Mr B asked the Environment Agency to help him because his pond had been polluted by run-off from a neighbouring farmer's field.

What happened

An Environment Agency officer went to Mr B's property to consider the incident. She gave Mr B and the farmer some advice. Mr B complained that the farmer had not complied and the Agency dealt with the complaint through various stages of its complaints process but did not uphold the complaint.

What we found

We found that the Agency had no duty to help Mr B with the incident and take action against the farmer. However, because it did not explain this to him at the time or at any point during the complaints correspondence, he did not understand and continued to believe that the Agency should have taken action. This caused him inconvenience and distress.

Putting it right

The Agency apologised to Mr B and paid him £100 because of the distress and inconvenience that its failure to properly explain its role caused. It also agreed to take action to make sure that, in future, both officers and complaint handlers clearly explain their role and responsibilities to customers.

Organisation we investigated

The Department for Environment, Food and Rural Affairs (Defra) – Environment Agency

Summary 11/March 2014

HM Courts & Tribunals Service failed to consider all the evidence when pursuing customer for fine

HMCTS failed to take into account an error by the police when it chased a customer for an unpaid traffic offence fine.

What happened

Ms A was given a fixed penalty notice. When the police wrote to her asking her to pay the fine, they did not tell her to do so within 28 days. Ms A missed the deadline and the police referred her fine to HMCTS. Ms A explained to HMCTS what had happened but it failed to take this into account when deciding whether she had to pay the fine. It later reconsidered its decision, taking into account the fact the police had not given Ms A a deadline, but its decision that Ms A needed to pay the fine remained the same.

What we found

HMCTS failed to take the missing deadline into account when it first considered Ms A's case. It eventually took it into account and reached the same conclusion that the fine still stood. Ms A lost confidence in HMCTS's decision making, which was why she did not then pay the fine when she was asked to. However, Ms A was still required to pay the fine so she did not suffer a financial injustice as a result of HMCTS's error.

Putting it right

HMCTS apologised to Ms A for its error in not taking into account the information she provided when it first considered her case.

Organisation we investigated

The Ministry of Justice – HM Courts & Tribunals Service (HMCTS)

Summary 12/March 2014

Driver and Vehicle Standards Agency denied problems with voiceover for driving theory test

The DVSA took over a year to admit that one of the questions in the Urdu voiceover of the driving theory test was mistranslated.

What happened

In mid-2012 Mr M took the driving theory test with an Urdu voiceover. The voiceover to one of the questions in the multiple choice section was mistranslated. Mr M wrote to DVSA to complain that the mistranslation had confused and distracted him in the hazard perception section and he wanted to appeal against the test score. DVSA said that there was no audio for that section of the test so the Urdu voiceover could not have affected his score. Mr M sent another six letters to DVSA but each time it told him that it was not aware of any problems with the voiceover and the test result could not be changed.

In mid-2013 the Independent Complaints Assessor (ICA) reviewed the complaint and found out that there were problems in the translation, which DVSA knew about, and the voiceover had been corrected shortly after Mr M took his test. DVSA had not told Mr M about this. The ICA recommended that DVSA pay him £50 as compensation for its poor complaint handling. The ICA found that Mr M would have been confused and distracted by the mistake but did not believe that it would have affected his performance in the hazard perception test. DVSA decided not to pay Mr M any compensation.

What we found

We agreed with the ICA's findings. The voiceover was incorrect but DVSA did not tell Mr M and its letters to him did not address his concerns. We also found that the mistake would have distracted Mr M but we agreed with the ICA's view that it was not possible to say that it would have directly affected his score in the hazard perception test.

'Mr M should not have had to write seven letters to DVSA to find out that he was right about the mistranslation.' The ICA

Putting it right

The DVSA agreed to apologise to Mr M, waive the fee should he retake the driving theory test, and pay him £50 compensation for the inconvenience caused by its poor complaint handling.

Organisation we investigated

The Department for Transport – Driver and Vehicle Standards Agency

Summary 13/March 2014

Driver and Vehicle Licensing Agency was right to impose a late licensing penalty

When Mrs B sold her car, she did not receive an acknowledgement from DVLA and she continued to be liable for paying tax on that car. When the tax expired, Mrs B incurred a late licensing penalty of £80.

What happened

Mrs B says that she told DVLA that she had sold her car but she did not get an acknowledgement from it. Without the acknowledgement, Mrs B remained responsible for the car. On a number of occasions, DVLA wrote to remind Mrs B that she needed to tax the car. Mrs B says she wrote to DVLA and tried to telephone them to explain that she had sold the car. DVLA says it did not hear from Mrs B and it issued a late licensing penalty of £80. Mrs B disputed the penalty because she said she had notified DVLA that she was no longer responsible for the car.

What we found

We looked at the law and guidance around transferring vehicles and we also looked at the information Mrs B and DVLA gave us.

Mrs B had a responsibility to let DVLA know that she had sold her car, and to telephone DVLA if she did not receive an acknowledgement within four weeks. While Mrs B said she had let DVLA know, we found no evidence that DVLA had heard from her. Without an acknowledgement from DVLA, Mrs B was still liable for the car.

We found no evidence to support Mrs B's claims that she contacted DVLA as she said, and we could find no evidence to show that DVLA received any contact from Mrs B before it issued the late licensing penalty. It was therefore reasonable for DVLA to impose the penalty. We found no maladministration on the part of DVLA, and we did not uphold Mrs B's complaint.

Organisation we investigated

The Department for Transport – Driver and Vehicle Licensing Agency (DVLA)

Summary 14/March 2014

HM Courts & Tribunals Service recognised unnecessary bailiff contact alongside administrative errors

A man faced unnecessary contact from a bailiff company because of miscommunication.

What happened

Following court proceedings, a debt relating to Mr P was passed to a bailiff company contracted to act on behalf of HMCTS. However, although the company was told that the proceedings were void, bailiffs failed to act on this information and wrongly proceeded with enforcement action.

As a result, Mr P received unnecessary contact from the bailiff company, including a visit to his home, which was distressing for him. Following his complaints, the bailiff company accepted the error but only offered a small payment in recognition of the stress caused. HMCTS also considered Mr P's complaint and found that, in addition to some minor errors and delay in its handling of Mr P's complaint, the bailiffs had not acted correctly. HMCTS offered him a total of £370 for the failings, which he considered insufficient.

What we found

Although the bailiff company had made errors in its handling of Mr P's case, these were likely to be a result of human error and did not indicate a wider systemic issue. HMCTS had acknowledged and accepted the errors and we were satisfied that it had offered a sufficient financial remedy. During our investigation we found that HMCTS had accidently sent a letter to Mr P's previous address.

Putting it right

We confirmed HMCTS's previous financial remedy was still available and asked HMCTS to apologise for sending a letter to the wrong address.

Organisation we investigated

The Ministry of Justice – HM Courts & Tribunals Service (HMCTS)

Summary 15/March 2014

Prison complaint handler's investigation of disability complaint was reasonable

Mr D complained that a prison took too long to give him special furniture, which he needed for his disability. He also complained about the way the Prison and Probation Ombudsman (PPO) handled his complaint.

What happened

Mr D suffered from pain that he described as a disability. He asked for a piece of furniture for his cell when he entered the prison but the prison turned his first application down. He complained to the PPO.

In the course of the PPO's investigation, and after a number of further applications and complaints to the prison, the prison gave Mr D the furniture he had asked for. As the outcome that he had wanted had been achieved, the PPO said that it would not uphold his complaint. Mr D complained to us about this decision and the length of time it took the PPO to investigate his complaint. He also said that the PPO had not considered the prison's complaint responses or other aspects of his complaint.

What we found

We did not think that it was unreasonable that the PPO took six months to investigate Mr D's complaint or that it was unreasonable for the PPO to focus its investigation on the outcome that he had wanted.

We could see that the governor of the prison explained to Mr D that he required a statement of Mr D's need for specific furniture from a medical professional who had examined him since he had arrived at the prison. We explained to Mr D that we considered the prison's response to why he was not initially given the furniture to be reasonable. We considered that it would have been more thorough of the PPO to look at this response in more detail but we did not think it was unreasonable for it not to do so, given that Mr D had now received the furniture he had asked for. Because of this, we did not uphold the complaint.

Organisation we investigated

The Ministry of Justice – Prisons and Probation Ombudsman (PPO)

Summary 16/March 2014

ACAS investigated own staff conduct

A complaint to the Advisory, Conciliation and Arbitration Service (ACAS) about a member of staff prompted it to investigate an employee's actions and inappropriate use of an email account.

What happened

An ACAS employee, who also worked for another organisation where she was effectively an employer, used her ACAS email account to advise her colleagues at the other organisation on employment matters. Several employees reported this to ACAS as an inappropriate use of the ACAS email account, because the employer was not acting in an official capacity as a representative of ACAS, and there was a conflict of interest. ACAS carried out two investigations but found no detriment to the other organisation's staff.

What we found

We investigated ACAS' handling of the complaints and found that it had not initially carried out a proportionate or fair investigation when it was first approached by four separate people. However, ACAS went on to identify its shortcomings and commission an independent and in-depth investigation. We concluded that ACAS' subsequent actions were sufficient to put matters right. We did not uphold the complaint against ACAS.

Putting it right

ACAS went on to strengthen and improve its email usage policy and to set up a national complaints process.

Organisation we investigated

The Department for Business, Innovation and Skills – The Advisory, Conciliation and Arbitration Service (ACAS)

Summary 17/March 2014

Delay at airport after UK Visas and Immigration wrongly withdrew an outstanding application

Ms F had an outstanding application for leave to remain. She travelled abroad but was delayed at the airport when she returned because UKVI had wrongly withdrawn her application.

What happened

Ms F applied for leave to remain. While the application was outstanding, she travelled abroad. UKVI subsequently withdrew her application; however, it has since acknowledged that this was incorrect in her circumstances. As a result of the confusion created by the withdrawal, Ms F was held at the airport for several hours. This was inconvenient and stressful for her. Further, by the time she was allowed to enter the UK, public transport had stopped and Ms F had to pay for a taxi home.

What we found

UKVI's incorrect withdrawal of Ms F's outstanding application for leave to remain caused her problems on her arrival at an airport.

We also found that UKVI handled some of her correspondence poorly.

Ms F also complained about UKVI's handling of her application for leave to remain. However, we did not uphold this part of her complaint.

Putting it right

UKVI apologised to Ms F, reimbursed her for the cost of her transport, and paid her £150 for stress and inconvenience.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 18/March 2014

Lost documents and poor complaint handling caused frustration and inconvenience

When processing his application, UKVI mislaid several of Mr B's original documents, including his birth certificate.

What happened

UKVI took nine months to make a decision on an application for indefinite leave to remain for Mr B and his family. When Mr B submitted his application, he supplied various original documents, including his birth certificate. UKVI mislaid these and could not locate them for over a month. Mr B complained to UKVI, but it unilaterally closed his complaint without responding to him. Its reasoning for this was that the application had been decided.

What we found

We upheld Mr B's complaints about the lost documents and the way UKVI had dealt with the complaint about them. UKVI should not have mislaid Mr B's documents and it should not have closed his complaint without sending a response. UKVI's actions caused Mr B frustration and inconvenience.

Despite the fact that the lost documents caused a brief delay in UKVI's consideration of Mr B's application, on these particular facts, the overall length of time taken to process the application was not unreasonable.

'UKVI lost my life history.' Mr B

Putting it right

UKVI had already offered Mr B £250. We agreed that was a reasonable amount to compensate Mr B for the inconvenience and frustration we identified. UKVI also apologised to Mr B.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Summary 19/March 2014

Unclear advice from Ofcom

When Mr A called the Office of Communications (Ofcom) for advice about his telephone line, it did not give him clear advice.

What happened

Mr A called Ofcom's advisory line as he had a problem with his telephone line. He could only make and receive calls when his telephone was plugged directly into the test socket. Mr A complained that Ofcom erroneously told him his telephone provider was responsible for the repair. He also complained that Ofcom incorrectly told him to take court action against his telephone provider.

What we found

We partly upheld Mr A's complaint and found that Ofcom's initial advice to him could have been clearer. However, after considering all of the evidence (including a recording of the initial call), we decided Ofcom did not advise him to issue court proceedings.

Putting it right

Ofcom apologised to Mr A for its unclear advice.

Organisation we investigated

The Office of Communications (Ofcom)

Summary 20/March 2014

Cafcass judgment should be challenged in court

A mother complained that the Cafcass officer assigned to her family was biased, but we found that it was reasonable for her concerns to have been raised in court.

What happened

Ms D complained that Cafcass left significant information out of the report it wrote about her children when their father tried to change the terms of the contact and residence order. Ms D said that Cafcass had ignored the way that the father had spoken to the children when they visited him, and this was because Cafcass was biased against her. Ms D said that Cafcass's bias was racially motivated because it also ignored her children's ethnicity in its report. Ms D said that Cafcass was no longer working on the case. However, both she and her children had been emotionally distressed by what had happened, and they now do not trust Cafcass.

What we found

The Cafcass officer had left important information out of her report. She acknowledged that she had done this, and she wrote a letter to the court to tell them about the missing information. We found that it was reasonable for Cafcass to have told Ms D that if she disagreed with any of the Cafcass officer's conclusions, she should have raised this in court. We found that Cafcass sent its response to Ms D's complaint to the court, so that the court would know that she was unhappy about it, and the Cafcass officer was also prepared to be questioned about her report in court.

However, this did not happen because the court removed Cafcass from the case.

There were some issues with Cafcass's record keeping, and complaint handling, but those were not significant enough to be maladministration. We did not uphold the complaint.

Putting it right

We made no recommendations in this case. Cafcass's letter to the court had corrected the mistakes in the original report, and its subsequent apology was sufficient for the distress Ms D and her children had suffered.

Organisation we investigated

The Ministry of Justice – Children and Family Court Advisory and Support Service (Cafcass)

Summary 21/March 2014

Misleading information on UK Visas and Immigration application form

Mr H complained that UKVI mishandled his application to stay in the UK as Mr E's civil partner. As a result, UKVI refused his application and he had no right of appeal.

What happened

Mr H, a South African national, wanted to stay in the UK as Mr E's civil partner. In spring 2012 he downloaded an application form from UKVI's website. The form gave details of the fee he had to pay. The only date available for Mr H and Mr E's civil partnership ceremony was also the last day of Mr H's visa. Mr H booked an appointment with UKVI to submit his application form immediately after their civil partnership ceremony, but UKVI cancelled the appointment. Mr H sent his application by post on the last day of his visa, immediately after his civil partnership. But UKVI rejected it because he had enclosed the wrong fee. Mr H sent another form with the correct fee but, because it arrived at UKVI after his previous visa had expired, his application was refused with no right of appeal.

What we found

We did not uphold Mr H's complaint. The fee for Mr H's application had increased between him downloading the form in spring and sending it to UKVI two months later. UKVI had no option but to reject Mr H's application because the law does not allow them to accept applications sent with the wrong fee. Mr H should have checked the fee was correct before he posted the application. UKVI was right to refuse Mr H's second application because when he had made it, his visa had already run out. Because of our investigation, UKVI agreed, exceptionally, to reconsider Mr H's second application. When it did this, it noted that a recent change to the law meant it could now treat Mr H's application as having been made in time. As a result of that change, it granted Mr H's application to stay in the UK.

Organisation we investigated

The Home Office – UK Visas and Immigration (UKVI)

Woman lost money when court hearing was cancelled at short notice

An administrative error by HM Courts & Tribunals Service (HMCTS) led to the cancellation of a scheduled court hearing.

What happened

The day before Ms W was due to attend a court hearing, HMCTS contacted her to say it had lost her paperwork and, as a result, the hearing had been postponed. Ms W complained that she had wasted the money she had spent on legal fees related to this hearing. In particular, she complained that she had lost the money she had paid to a barrister who had been due to represent her at the hearing.

What we found

We partly upheld Ms W's complaint. Although Ms W had been affected by HMCTS's error, we did not think this meant she had wasted all of the money she had paid. We felt that much of the work done in preparation for the hearing would still be relevant once the hearing was rearranged.

However, we agreed with Ms W that the money she had paid to the barrister had been wasted. This was because Ms W could not have this money refunded to her and, if she wanted a barrister to represent her at another hearing, she would have to pay this money again.

Putting it right

HMCTS apologised to Ms W for the inconvenience its administrative failure had caused her and agreed to pay her £100 for this. It also agreed to pay her £3,600, plus interest, for the money she had paid to the barrister.

Organisation we investigated

The Ministry of Justice – HM Courts & Tribunals Service (HMCTS)

Summary 23/March 2014

Error by HM Courts & Tribunals Service delayed eviction of tenant

A couple were forced to wait longer than necessary for an unwanted tenant to leave their property.

What happened

Mr and Mrs S took their tenant to court because they failed to pay rent. A judge ordered the tenant to leave the property by a specified date or face formal eviction. The judge also ordered the tenant to pay the outstanding rent. Unfortunately, HMCTS issued an incorrect court order that suggested that the tenant could remain in the property if he made arrangements to pay the outstanding rent. Although Mr and Mrs S successfully challenged the incorrect court order, the time taken to do so meant that the tenant stayed in the couple's property for longer than should have been necessary.

What we found

HMCTS's error in issuing the incorrect court order caused stress and inconvenience to Mr and Mrs S. Furthermore, at first HMCTS did not handle the couple's complaint about what had happened properly. However, by the time the complaint came to us, HMCTS had acknowledged its mistakes and apologised to Mr and Mrs S. HMCTS had also paid the couple about £750 for the stress and inconvenience they had suffered.

Because we were satisfied that HMCTS had taken reasonable steps to put right the mistake it had made, we did not uphold Mr and Mrs S's complaint.

Organisation we investigated

The Ministry of Justice – HM Courts & Tribunals Service (HMCTS)

Healthcare cases

Summary 24/February 2014

Older man left frustrated and out of pocket in continuing healthcare assessment (CHC) claim

When Mr R made a retrospective CHC claim for NHS funding for his wife, he was told to pay for copies of her records.

What happened

Mr R complained to us after his primary care trust (PCT) told him that he had to pay his wife's nursing home £50 for copies of her records. We tried to persuade the PCT to change its position on this, but were unsuccessful. Mr R had no option but to pay the charge for the assessment to go ahead. He complained to the PCT and then approached us again.

As a result, Mr R said, he had been left out of pocket and discriminated against because his clinical commissioning group (CCG) was not operating a fair system. He was also unhappy with the CCG's response to his complaint and the time it took to reply.

What we found

The National Framework makes it clear that CCGs have to carry out the process of assessing eligibility for CHC funding. In order to do that properly they need to consider all relevant evidence, including care records. Inevitably there will be times when they will have to pay an administrative overhead to get the information they need. The NHS should not depend on patients or their relatives paying these costs. We did not see any evidence that the CCG discriminated against Mr R but we agreed that the CCG should not have charged him and was not operating a fair system.

The CCG did not give Mr R a reasonable explanation for why it asked him to pay the nursing home's charge. Indeed part of its response to him seemed to have been intended to mislead. Here, the CCG did not act in line with the complaints regulations. It had said that it would reply to his complaint in six weeks but it took about four months to get back to him.

Putting it right

We recommended that the CCG should write to Mr R to apologise for its failings and to repay the £50 fee, along with £250 for his time, trouble and frustration. We also recommended that the CCG should see if it had any other cases where it had passed on charges to claimants, and to offer them an apology and a refund.

Organisation we investigated

A clinical commissioning group (CCG)

Summary 25/February 2014

Ambulance trust denied woman transport

Mrs L, who has difficulty walking, complained she was unfairly denied patient transport for her physiotherapy appointment despite getting transport regularly in the past.

What happened

Mrs L regularly attends physiotherapy appointments. She used the patient transport service to attend her appointments. In early 2012 she phoned to book patient transport for an appointment but staff told her that she was not eligible. Initially the East of England Ambulance Service NHS Trust told her that this was because she received the higher rate mobility component of disability living allowance (DLA) but staff later offered her a medical assessment and clarified that she did not meet the criteria for patient transport because she did not have a medical need for it. The criteria had not changed but the Trust had become more rigorous in applying them. Mrs L complained to the Trust and to the commissioning organisation, Suffolk PCT, about the decision, and also that staff were rude to her. She said that it was unfair to make a decision about her eligibility based on whether or not she was getting the higher rate mobility component of DLA.

What we found

Ambulance Trust staff made some inappropriate comments to Mrs L about the significance of her receipt of DLA, and wrongly implied that their decision would be based on that alone. A member of staff was also disrespectful in some of his comments. However, we considered it appropriate for staff to take into account whether or not Mrs L received the benefit. They also took into account other relevant factors, including whether or not she had a medical need for patient transport. Therefore, they made a fair decision about her eligibility. We did, however, find that some Trust staff seemed to believe that their criteria meant that recipients of the higher rate mobility component of DLA were ineligible for patient transport. We shared our concerns about this with the Ambulance Trust.

Suffolk PCT carried out a reasonable review of the Ambulance Trust's assessment and reached a fair conclusion.

Putting it right

During the course of our investigation the Ambulance Trust apologised to Mrs L for the inappropriate manner of their staff.

Organisations we investigated

East of England Ambulance Service NHS Trust

Suffolk PCT

Summary 26/March 2014

Cancer should have been diagnosed sooner

Mr K's GPs and NHS trust treated him for a common hip problem for several months before the condition was found to be a rare cancer.

What happened

Mr K saw his GP in late 2010 because of a problem with his hip. He was treated over several months for a relatively common complaint. After a few months of unsuccessful treatment, his GP referred him to the Trust. The Trust's physiotherapist found a lump and asked for further investigations. After a specialist opinion, Dr Z, a doctor at the Trust, saw Mr K. Neither the Trust nor Mr K told Dr Z that a lump had been found and the doctor treated Mr K for the hip problem. During an ultrasound guided injection, a radiologist saw the lump and arranged investigations that led to the lump being diagnosed as cancerous. The lump had spread to his lymph nodes. Mr K has since undergone extensive treatment.

What we found

We could not say that the cancer should have been diagnosed by the GPs, or that they failed to take appropriate action. The lump was not very large at that time, and we could not say whether or not Mr K mentioned a lump to the GPs. However, the Trust's care was inadequate. After its physiotherapist found a lump, it failed to act with sufficient urgency and did not plan Mr K's care appropriately. By the time Dr Z examined Mr K, the lump was such a size that he should have found it. We could not say whether the Trust's failings led to the cancer spreading to Mr K's lymph nodes, but the failure to diagnose the cancer earlier increased the chance that the cancer would spread and compromised Mr K's chances of survival in the longer term.

Putting it right

The Trust has investigated the complaint thoroughly and has identified a number of actions to improve its service. Following our recommendation, it paid Mr K £500 in compensation.

Organisation we investigated

Cambridgeshire Community Services NHS Trust

Summary 27/March 2014

NHS trust failed to provide adequate care for an older person

Mrs L had a history of high blood pressure, asthma, chronic constipation and bowel obstruction. She did not get the right care when she went into hospital.

What happened

In early 2011 Mrs L (then in her nineties) became increasingly frail. Her doctor referred her to the hospital because of an impacted bowel. Doctors assessed her and treated her for constipation. Mrs L transferred to a ward soon after admission. In the next few weeks, her condition fluctuated. Later in the month, nurses found Mrs L to be unresponsive. Staff attempted to resuscitate her but she had died. Her son, Mr L, complained to us.

What we found

There were fundamental failings in Mrs L's care and treatment, especially around her situation as a frail, older person. There was some good nursing care; however, there was an overwhelming failure to provide '*person-centred care*'. Assessment, review, monitoring and treatment of Mrs L's eating and drinking and constipation were consistently poor. Doctors and nurses did not act in line with the applicable standards. Further, communication with the family was not in accordance with the relevant standard. Taken together, these failings meant the care and treatment Mrs L received fell so far below the applicable standards that it was service failure.

Putting it right

Following our report, the Trust acknowledged the failings we identified and apologised for the injustice these caused. The Trust agreed to pay £1,250 compensation to Mr L and to prepare an action plan to make sure it learnt lessons from the complaint.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Summary 28/March 2014

Failure to spot sepsis led to missed opportunity to treat patient

Mr F complained about the death of his mother after a hysterectomy. He said that the hospital had not given appropriate postoperative care and that her death was avoidable.

What happened

Mrs F was admitted to hospital for a hysterectomy, which was performed without incident. A blood test taken after surgery showed that she had an infection, but neither the consultant who operated on her nor the doctor on duty reviewed this. Staff monitored Mrs F regularly and recorded her deteriorating condition but did not tell a senior clinician. It was not until a shift change two days after the operation that a nurse realised the severity of her condition and contacted a senior doctor. Mrs F was transferred to an acute hospital but did not respond to treatment and died the following day.

What we found

The consultant and the doctor on duty should have reviewed Mrs F's blood test results and should have noticed the indication of infection. Nursing staff should have passed on concerns at a much earlier stage. Had these actions happened, it is likely that Mrs F would have been treated much earlier. There was a lost opportunity to give her the treatment she needed. However, given the severity of the condition, we could not say that she was more likely to have survived. During the complaints process, the hospital commissioned an independent report that was highly critical of the care provided. However, the hospital did not take any action as a result of this report and never apologised to Mr F for the failures that occurred.

Putting it right

The hospital apologised to Mr F and produced an action plan to address the failings identified. We did not recommend financial compensation as Mr F said that he did not want such a remedy.

Organisation we investigated

Ramsay Healthcare UK – Rivers Hospital

Summary 29/March 2014

NHS trust failed to record care planning and delayed addressing the complaint

Mr B died in hospital. The Trust could not reassure his family that the care he received was good because some records were sparse. The Trust's complaint handling was also poor.

What happened

Mr B was admitted to the Trust with chronic fatigue and lethargy. After a week in hospital, he had a heart attack and a few days later passed away. His family complained about Mr B's clinical care, nursing care and deterioration in condition while in hospital. The Trust handled the initial stages of the complaint quite well but was unable to reassure the family that Mr B had received good care.

What we found

Although Mr B had received a good standard of care, the Trust had not fully answered some questions. Mr B's care plans had not been recorded properly but this did not affect his care. The Trust took a long time to give us the information we needed to complete our investigation.

Putting it right

We said that the failures in recording should be addressed to avoid them happening again, and the Trust should apologise for them. We also said that the Trust should apologise to the family for the delays it caused in the later stages of the complaints process and pay them £250 for the additional distress this caused. We felt that the failings in complaint handling were so significant that the Trust should analyse why these happened, produce an action plan to put things right and send it to the Care Quality Commission.

Organisation we investigated

Central Manchester University Hospitals NHS Foundation Trust

Summary 30/March 2014

Trust missed several chances to diagnose fatal condition

A trust misdiagnosed a patient as having a blood clot when he actually had an aortic dissection (a tear in the blood vessel from the heart to the body). This resulted in his death.

What happened

Mr F went to A&E with intense pain in his arm. Staff diagnosed a blood clot, scanned him and gave him anticoagulation medication to thin his blood. Later that night Mr F collapsed and died. His post mortem found an aortic dissection that had blocked the flow of blood to his arm, not a blood clot. Mr F's wife complained to the Trust about her husband's misdiagnosis. The Trust did not uphold her complaint because Mr F did not have the usual chest pain it expected in someone with an aortic dissection.

What we found

Mr F's symptoms were not typical for his condition, which made it more difficult to diagnose. However, the Trust missed several chances to correctly diagnose Mr F, including taking account of his previous medical history and unusual symptoms, carrying out a chest X-ray and misreporting a scan. While we cannot say that Mr F's death was avoidable (because his condition was very serious), it is clear that the Trust lost the chance to give him treatment that might have prevented or delayed his death.

'We identified a number of missed opportunities in the care provided to Mr F. While individually these would not all be considered failings, cumulatively they amount to service failure.' Dame Julie Mellor, DBE

Putting it right

We recommended that the Trust apologise for and acknowledge its mistakes and pay Mr F's wife £2,000. We also asked the Trust to identify in an action plan how it would avoid these failings happening again.

Organisation we investigated

University Hospitals Birmingham NHS Foundation Trust

Summary 31/March 2014

Woman needed more surgery after Trust failed in care after operation

After a hysterectomy, staff took out Mrs A's catheter without considering the significance of '*pink urine*', as recorded in the notes. This resulted in a bladder injury that needed additional surgery to repair.

What happened

Mrs A had a hysterectomy in 2011. After she left hospital, she was uncomfortable and leaked urine and was referred back to the Trust by her GP. She was referred to a urologist and had surgery to repair her bladder. Mrs A was concerned that the damage happened during her hysterectomy.

What we found

Although the Trust carried out Mrs A's hysterectomy correctly, it failed in the care it gave her after her operation. Specifically, it failed to monitor her urine and when removing her catheter.

Putting it right

The Trust agreed to apologise to Mrs A and to pay her £1,500 as compensation for the distress, pain, further surgery and the longer recovery period she experienced. The Trust also agreed to put together an action plan that showed how it had learnt from its mistakes so that they would not happen again.

Organisation we investigated

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Long delay in a GP's referral

Mr B visited his GP because of his headaches. His GP said that he would refer Mr B to a neurologist for further investigation of his symptoms but there was a long delay in making the referral.

What happened

Mr B had to chase the GP Practice about the referral, and was given conflicting information about what had happened to it. This was very frustrating, worrying and time-consuming for him. He was also unhappy that the Practice did not respond to his written complaints to them.

What we found

The Practice gave us copies of letters that it had sent Mr B in response to his complaint. While we understood that Mr B had not received them, we could not find out why this was, and it may have been due to events beyond the Practice's control. So we did not uphold this aspect of the complaint.

We upheld Mr B's complaint about the delayed referral. In response to this, the Practice acknowledged there was a delay and apologised for it. However, we found that it did not explain the delay in the referral and it did not say what it would do to prevent it happening again.

'*I hope that* [the Practice] *take this feedback and use it as an opportunity to learn from my experience, and change* [its] *systems and services so another patient does not have to go through what I have been going through*.' Mr B

Putting it right

The Practice acknowledged and apologised for its failures and the impact these had on Mr B, and detailed what action it has taken to make sure that its referrals will be made correctly and promptly.

Organisation we investigated

A GP practice

Failings in care did not lead to patient's death

Mrs R's daughter, Mrs S, complained that her mother should have been cared for in an acute hospital rather than a community hospital and that she received poor care which resulted in her death.

What happened

Mrs R, then in her eighties, had surgery to repair a fractured hip. She had a stroke in hospital shortly afterwards. She was transferred to a community hospital for rehabilitation, where she was found to have MRSA (a bacterial infection) in her surgical wound. She was very agitated and distressed during her admission and doctors gave her a drug to try to help with these symptoms.

Mrs R became extremely unwell and was transferred to an acute hospital. She developed a swallowing difficulty and died from aspiration pneumonia after she was transferred.

What we found

Doctors at the community hospital did not see Mrs R often enough or communicate well with Mrs S. This was a failing. She was too unwell for rehabilitation and should have been cared for in an acute hospital, where she would have had access to 24-hour care and treatment. She would have had better treatment for her MRSA had she been in an acute hospital, although her infection eventually cleared up with less intensive treatment.

Nurses did not properly monitor Mrs R's eating and drinking, although this might not have made much difference for Mrs R, who was very unwell. It was upsetting for Mrs S to see that her mother did not get the standard of care she was entitled to.

There were failings in the care provided to Mrs R, and missed opportunities to provide her with better care and treatment. However, it is more than likely that the course of events would have been no different had the failings not happened. Mrs R was very ill, with several health problems (such as the stroke, which contributed to her death) and there was little, if anything, that could have been done to make these better.

Putting it right

The Trust acknowledged the failings we identified and apologised for the injustice that resulted from them. It also paid Mrs S £750 compensation in recognition of the injustice she suffered.

The Trust is producing an action plan to show that it has addressed the failings identified during our investigation.

Organisation we investigated

Worcestershire Health and Care NHS Trust

Trust did not assess patient's circumstances before discharging him from hospital

Mr B suffered from heart failure and several other chronic illnesses. He was admitted to hospital after experiencing shortness of breath. He was discharged the next day, but was readmitted that same evening, and died the following day.

What happened

Mr B's son complained that his father was too unwell to be discharged from hospital, and that this led to his death. He was also unhappy that his father was left to get a taxi home by himself, and that no one contacted the family to let them know.

The Trust explained that Mr B was assessed and found to be medically suitable for discharge. It also said that it was not routine to inform a patient's family when they were returning home if the patient was able to tell their family themselves.

What we found

Medical records supported the Trust's response that Mr B was suitable for discharge, and we concluded that the discharge was clinically reasonable. We did not uphold this aspect of the complaint.

However, the Trust should have assessed Mr B's social needs before he was sent home to make sure he could get home safely and had support in place. We upheld this aspect of the complaint.

'*May I take this opportunity to personally thank you and the team ... for keeping us updated throughout the whole process and for a very informative report.*' Mr B's son

Putting it right

The Trust agreed to acknowledge and apologise for not assessing Mr B's social needs, and the distressing impact this had on his family. It also agreed to confirm what action it had taken to make sure that assessments were carried out in the future.

Organisation we investigated

University Hospitals Coventry and Warwickshire NHS Trust

GP failed to thoroughly assess patient with ulcer

Mr A saw a GP after having severe stomach pain. The GP failed to thoroughly assess him or consider a stomach ulcer as a possible cause for his pain.

What happened

Mr A had suffered from stomach pain for several days. He had a blood test at his GP Practice, which was positive for bacteria (Helicobacter pylori) that are the cause of most stomach and bowel ulcers.

During Mr A's appointment with the GP, Mr A said that his pain was severe. The GP did not examine him, take his vital signs, test his urine, or consider a stomach ulcer as possible cause for his pain. The GP diagnosed irritable bowel syndrome. The GP also advised Mr A to wait to see a gastroenterologist that the Practice planned to refer him to. However, after the appointment, Mr A went straight to hospital, where he was diagnosed with an ulcer.

Mr A and his father felt that the GP had put Mr A's life at risk, and were angry about this. Mr A and his father complained that the GP's response to their complaint was inaccurate.

What we found

The GP did not adequately assess Mr A's condition. Had he done so, it is likely that he would have referred Mr A to hospital for urgent treatment. If Mr A had followed the GP's advice and waited for the referral to the gastroenterologist, his life could have been at risk. That said, Mr A's life was not, in the event, put at risk by the care he received from the doctor because he went straight to A&E after the appointment.

In response to the complaint, the GP said that he noted the test result for Helicobacter pylori but that it was '*essentially normal*', which is incorrect and of concern.

We found no maladministration in the Practice's complaint handling.

Putting it right

We recommended that the GP Practice apologise to Mr A and his father. We also recommended that the GP should put in place a plan to address the failings in his assessment of Mr A.

Organisation we investigated

A GP practice

GP's actions led to death of man in late 50s

A GP did not spot a life-threatening condition that led to the patient's death a few hours later.

What happened

Mr B had sinusitis symptoms and made an appointment to see his GP. However, the night before the appointment Mr B had other, much more serious symptoms including stomach pain and vomiting, and feeling faint and dizzy. Mr and Mrs B went to the GP as planned and described the symptoms Mr B now had, as they were very worried. The GP examined Mr B and said he had sinusitis. The GP gave Mr B antibiotics and Mr B went home. His serious symptoms continued. Later in the day, Mrs B went out. When she came back, Mr B had died. Mrs B complained to the GP Practice that the GP had not examined her husband properly. The GP Practice tried to resolve Mrs B's complaint. However, once it was clear that Mrs B and the GP disagreed about what happened during the appointment, the Practice said there was nothing more it could do.

What we found

The GP did not examine Mr B as thoroughly as he should have done, especially in relation to his stomach pain. He did not listen to the information about the more serious symptoms. He should have urgently sent Mr B to hospital for an operation. If that had happened, Mr B probably would not have died.

The Practice wrongly presented the GP's account of events as the outcome of its investigation into what happened. To find out what happened and to try to resolve Mrs B's complaint, the Practice should have asked for an independent view. Instead, it stopped trying to resolve Mrs B's complaint once it was clear that there was a serious and ongoing disagreement about what had happened.

Mrs B lost her husband as a result of the GP's failure to recognise a serious illness, and she suffered further distress because the Practice took the GP's account of events as definitive. The Practice effectively stopped its investigation once the conflict in accounts became clear.

'*The GP heard the word "*sinus*" at the beginning of the consultation and did not look any further for a cause of his illness.*' Mrs B

Putting it right

The Practice agreed to acknowledge the failings, apologise for their impact, and pay Mrs B £15,000 compensation. It also agreed to take action to prevent the same thing happening in future. The GP agreed to acknowledge his failings and apologise to Mrs B.

Organisation we investigated

A GP practice

GP over-prescribed morphine, probably causing a seizure

Ms C suffered from back pain on and off for several years. Her GP prescribed morphine to lessen the pain.

What happened

The day after being prescribed the drug, Ms C was getting her baby and young daughter ready for bed when she had a seizure.

What we found

The GP had prescribed a dose of morphine that was twice the recommended daily dose and, on the balance of probabilities, this triggered an epileptic seizure.

'I just wanted him to recognise what he'd done and the effect it's had on me and my family.' Ms C

Putting it right

The serious nature of the events continues to have a significant impact on Ms C and her family. The GP has apologised to Ms C and has acknowledged the impact the failings had on her. He has discussed the findings of this complaint with his responsible officer, and has paid Ms C £1,000.

We shared our report with the GP's responsible officer and the NHS England local area team.

Organisation we investigated

A GP practice

Summary 38/March 2014

GP practice failed to investigate breathlessness in man with heart and kidney problems

Mr B had health problems including kidney disease, high blood pressure and heart failure. He could not go out without help. His family complained that poor GP care and treatment led to Mr B's deterioration and death.

What happened

When Mr B suddenly became short of breath, his family contacted his GP Practice. A GP spoke to the family over the telephone and, believing that Mr B had heart failure, increased his dose of diuretic. Two months later, Mr B was again short of breath and a GP visited him at home. The GP again increased Mr B's diuretic, and referred him to a community heart failure nurse. Mr B was short of breath over a month later and his family went to the Practice for advice. The Practice told them to talk to the heart failure nurse. Mr B's breathing and kidney problems deteriorated over the next few months, and he died.

What we found

The Practice provided some appropriate care for Mr B. However, there were also serious failings. The Practice did not visit Mr B at home and examine him all the times it should have, and did not investigate Mr B's sudden breathlessness, or refer him to a cardiologist when he was first short of breath. Plans to follow up Mr B were inadequate, and a GP did not assess the situation before the Practice told Mr B's family to talk to the heart failure nurse. Also, the Practice did not do all that it should have to ensure effective communication with Mr B's family. Our investigation concluded that while these failings caused Mr B anxiety, discomfort, and distress, and were also upsetting and distressing for his family, they did not lead to Mr B's death.

Putting it right

We recommended that the Practice write to Mr B's family to acknowledge the failings, and to apologise for the injustice this caused. We also recommended that it develop an action plan to learn lessons from the complaint.

Organisation we investigated

A GP practice

Trust failed to properly record and monitor the sodium it gave patient

Ms Q received sodium as part of her liver disease treatment but a lack of proper records meant the amount she received and how quickly is unknown. Her mother, Mrs U, complained on her behalf.

What happened

Ms Q was admitted to hospital and diagnosed with liver disease. She had a low potassium level and was given replacement potassium through a sodium solution. Daily blood tests monitored her sodium and potassium levels, but one crucial blood test was cancelled. There were no nursing records, which meant that the amounts of solution Ms Q received and when, along with the levels of fluid she excreted, are unknown.

Ms Q began to show signs of confusion and difficulty in speaking. A brain scan showed that she had central pontine myelinolysis (CPM), which can be caused by too rapid a rise in sodium levels. Ms Q deteriorated and died of CPM three weeks after she was admitted to hospital.

What we found

The Trust's record keeping was below standard, which severely hampered our investigation. Without the records, we were unable to say whether Ms Q had received too rapid a rise in sodium. Her monitoring was not in line with the applicable standard and the cancelled blood test was contrary to established good practice. The Trust's complaint handling was poor and the lack of records prevented it from answering Mrs U's complaint. Because of the lack of records, we were unable to say what had caused the CPM, but there was a possibility that it had arisen spontaneously due to Ms Q's liver disease.

Putting it right

The Trust apologised to Mrs U and produced an action plan to prevent it happening again.

Organisation we investigated

Nottingham University Hospitals NHS Trust

NHS trust did not reassess older woman and so missed opportunity to give treatment

Mrs A complained that the Trust did not provide adequate care and treatment for her mother, Mrs B, after she was admitted to hospital with diarrhoea and vomiting. She also complained that the Trust did not keep adequate records of her mother's care, communicate appropriately with the family or handle her complaint properly.

What happened

Mrs B was admitted to hospital with diarrhoea and vomiting, which doctors diagnosed as gastroenteritis. Her diarrhoea stopped but her vomiting continued. Mrs B's condition significantly deteriorated five days after admission. Surgeons reviewed Mrs B and suggested that she might have a bowel obstruction. By that time it was too late to do a scan or operate. Mrs B died shortly afterward.

What we found

Given that Mrs B was not improving, doctors should have carried out further tests to assess Mrs B's kidney function and to see whether she had any other signs of infection. But no tests were done. We also found there was a lack of input from senior doctors during Mrs B's time in hospital. Although nurses appropriately monitored Mrs B's physiological observations, and increased observations when necessary, they failed to keep adequate records of her care, particularly her fluid input and output. The nurses also did not adequately communicate with Mrs B's family. We could not say, however, that Mrs B's death could have been prevented.

Shortcomings in the Trust's complaint handling were not so serious as to be maladministration.

Putting it right

The Trust agreed to write to Mrs A to acknowledge the failings and apologise for the injustice caused, pay £3,500 compensation and provide an update on the action plan it had developed to address the failings we identified.

Organisation we investigated

Barking, Havering and Redbridge University Hospitals NHS Trust

Dentist failed to check that the medicine she prescribed was appropriate

A dentist prescribed medicine to Mrs A that could have affected other medicines she took. Mrs A made a number of complaints that the Practice did not respond to fully in writing.

What happened

Mrs A saw a dentist with a wisdom tooth infection. She complained about the dental care she received. The Practice removed her from their list because of a breakdown in the relationship. When she made a further complaint, the Practice suggested a meeting. Mrs A could not attend a meeting and asked for a written response but the Practice failed to respond to all the issues.

When the Practice did not respond in writing, Mrs A contacted us. The Practice sent a final written response after we contacted it.

What we found

The majority of Mrs A's care was reasonable. But the dentist failed to check how the medicine she prescribed to Mrs A would affect the other medicines she took. Mrs A was aware of possible effects. She was left in pain for two days because she had to wait until after the weekend to check the medication with her GP.

The Practice failed to fully respond to Mrs A's complaints. It knew about the NHS complaints regulations but this time it got it wrong.

Putting it right

We recommended that the Practice apologise to Mrs A for its mistake and pay £250 in compensation for her unnecessary pain and suffering and not responding in writing to all the issues raised.

We also recommended the dentist should discuss the complaint with her responsible officer and tell us and Mrs A what she had learnt from the complaint about prescribing medication.

Organisation we investigated

A dental practice

Despite minor shortcomings, hospital and ambulance service provided reasonable response to complaint

Mr L went into urinary retention after a biopsy procedure. He called an ambulance and was taken to A&E. He complained about various aspects of the care he received from the ambulance service and the hospital.

What happened

Mr L had a biopsy procedure at the hospital. After he was discharged he experienced the common complication of urinary retention and so called an ambulance. Mr L was not happy with the attitude of the ambulance staff. He also said that he could have been offered pain relief sooner and that he had walked to and from the ambulance unaided.

When he arrived at hospital, Mr L said that there was a delay in the hospital carrying out the catheterisation he needed to relieve his condition. He also said that he was not offered a drink in A&E, staff did not wear gloves when they took blood samples, and that the attitude of an A&E nurse was poor.

What we found

Pain relief was offered seven minutes into the ambulance journey, and we thought that this could have been offered slightly sooner. Although this was a shortcoming, we did not consider that this minor delay was serious enough for us to uphold the complaint. There was no evidence that the ambulance service did anything else wrong, and its response to the complaint was reasonable.

There was no evidence of poor care on the part of the hospital, although the hospital's records of the catheterisation were incomplete. We did not uphold the complaint because, even though the records were incomplete, it was clear that staff carried out the procedure in reasonable time.

Parts of Mr L's complaint were about interactions with staff and there was not any evidence of what had happened, particularly where Mr L was concerned about staff attitude. We explained to Mr L that we would not be able to say whether anything had gone wrong, but we thought that both organisations had provided reasonable responses to these parts of the complaint and had apologised for any distress Mr L felt.

Putting it right

We noted areas where each organisation could have done slightly better, but we did not think that these minor shortcomings were serious enough to uphold the complaint. However, we highlighted these issues so that the organisations could take them forward as learning points.

Organisations we investigated

East and North Hertfordshire NHS Trust

East of England Ambulance Service NHS Trust

Mental health trust provided appropriate support

Mr U wanted more psychological therapy and support to find housing.

What happened

Mr U complained that the Trust did not provide therapy for him, that it changed his diagnosis but did not tell him, and that it did not help him with his housing. He said it discharged him from services and left him without care after he complained. Mr U wanted the Trust to provide him with the services he was entitled to.

What we found

The Trust's records showed that Mr U received therapy on a number of occasions and that it sent a letter of support when he asked for help with housing. The Trust did not discuss Mr U's change in diagnosis with him at first, but it did so when it realised that he was not aware of the change. We did not uphold the complaint because we felt the Trust had taken appropriate action to address this failing.

Organisation we investigated

Lancashire Care NHS Foundation Trust

Summary 44/March 2014

Wife distressed by poor standard of hospital care her husband received

Mr P was admitted to hospital with a fractured right ankle which, because of his underlying medical conditions, was a serious injury.

What happened

An outbreak of norovirus meant that Mr P spent seven days on an assessment ward. His wife felt that the layout of the ward meant that her husband could not build relationships with staff and so he was not given help with his fear of hospitals. She became concerned when she realised her husband was not eating hospital food and she found dirty wound dressings, kitchen utensils and laundry near his bed. She also thought he wasn't being given his usual medication. When the decision was taken to transfer Mr P to another ward, the transfer took place in the early hours of the morning and his wife was not told. It only became apparent that Mr P was suffering from bedsores when he was transferred again. Mr P's family found what they considered to be a lack of care distressing at an already difficult time.

What we found

There were failings in care and monitoring around Mr P's transfer, nutrition and pressure sores and these were made worse by poor record keeping. However, Mr P was appropriately placed on the ward, regularly spoken to and properly given his medication. The Trust had already recognised failings in cleanliness and dressing disposal and had taken proper action about that.

Putting it right

The Trust wrote to Mrs P to apologise for failings and the upset it caused and explain what action it had taken to make sure this doesn't happen again. The Trust also paid Mrs P £750.

Organisation we investigated

Sheffield Teaching Hospitals NHS Foundation Trust

Hospital misinterpreted a scan of patient with lung cancer

Mr A had a scan at a hospital trust that showed abnormalities, but which the Trust said was clear.

What happened

Mr A had been feeling unwell and suffering from a persistent cough and chest pain. He went to the Trust and was given a scan, which the Trust said was clear. However, another scan at the Trust less than two months later showed that he had lung cancer and secondary cancers in his liver and spine. Mr A died around two months later.

Mrs A complained to the primary care trust (the PCT). It obtained the opinion of an independent radiologist on the first scan, which the Trust had said was clear. The independent radiologist concluded that the first scan had shown abnormalities suggesting cancer.

When PCTs were abolished in April 2013, NHS England took over the PCT's responsibility for handling the complaint. It told Mrs A that the independent radiologist whose opinion the PCT had obtained had some concerns about how the Trust had reported the first scan.

What we found

The Trust should have identified the abnormality on the first scan when it first reported on this. When the Trust wrote to Mr A's GP about the second scan, it should have emphasised that the cancer had spread to Mr A's spine, but it did not do so.

NHS England was not open and accountable in handling the complaint because it did not tell Mrs A about the independent radiologist's conclusion that the first scan had shown abnormalities suggesting cancer.

Putting it right

We recommended that the Trust and the NHS England apologise to Mrs A. We also recommended that the Trust should put in place a plan to address the failings we identified.

Organisations we investigated

NHS England East Anglia Area Team

Norfolk and Norwich University Hospitals NHS Foundation Trust

GP and NHS trust provided poor care for broken neck

While Mr F was in prison, he suffered a neck injury. He was unhappy about the care he received.

What happened

The prison GP examined Mr F and called an ambulance that took him to the local A&E department, where he had a scan. Staff thought he had a soft tissue injury and discharged him. When the doctors looked at the scan again a few days later, they saw that Mr F had broken a bone in his neck. They called him back to hospital for further treatment, which included giving him stronger painkillers.

Mr F complained about the care he had received. He said the GP's examination had been painful and made his injury worse. He also said the hospital had failed to diagnose his injury correctly and left him in severe pain.

What we found

The GP's examination and record keeping fell short of the relevant standards and the hospital should have done more to diagnose Mr F's injury, particularly because neck injuries can be very serious.

However, Mr F did not suffer long-term damage as a result of the failings. Although he has experienced pain and reduced movement in his neck, the doctors who treated him said he was healing well. There was no evidence that his problems were caused or worsened by the care he received, rather than by his original injury. When the hospital found out Mr F had broken his neck, it gave him stronger painkillers. Therefore we could say that if it had diagnosed his broken neck straight away, it would have given him stronger painkillers sooner. Mr F was left in pain for some days because the incorrect diagnosis meant he was not given strong enough painkillers.

Putting it right

We recommended that the GP Practice should apologise to Mr F for the shortcomings in his care. We also recommended that the Trust should apologise to him and offer him £250 in compensation for the avoidable pain he had suffered for several days. Both organisations accepted our recommendations.

Organisations we investigated

Cambridge University Hospitals NHS Foundation Trust

A GP practice

Inappropriate discharge of terminally ill patient caused patient and family distress

Ms P, who was terminally ill, was discharged from hospital without appropriate checks that she could manage at home. She had to be readmitted the following day by emergency ambulance.

What happened

Ms P went into hospital with severe abdominal pain. She was treated for constipation and discharged home two days later.

Ms P's family explained that she was too ill to manage the stairs at home so she had to spend the night on the sofa. The next day her partner contacted a hospice for advice as he was so concerned. A nurse from the hospice attended and told them to call for an emergency ambulance to take Ms P back to hospital. She died a few days later.

What we found

Ms P was known to have an existing hemiparesis (a weakness of one side of the body) caused by metastatic disease. She was also known to the oncologists at the Trust. However, there was no assessment of her disability or deterioration in her disease status. The nursing staff also failed to properly assess whether she could manage at home.

Ms P was unable to cope at home and had to spend the night on a sofa because she could not manage the stairs. Although she was taken back to hospital by ambulance the next day and she died shortly after, we could not link the failings to the subsequent decline in her health. However, the failings caused considerable distress to Ms P and her family, who had to look after her at home and witness the distress she was in.

The failings were exacerbated by poor complaint handling by the Trust. It took too long to respond and its responses were not sufficiently detailed and did not give assurances that action would be taken to put right any failings.

Putting it right

We recommended that the Trust formulate an action plan to address the failings identified in our report and prevent similar situations happening again. We also recommended that the Trust apologise for the failings in its handling of this complaint and make a financial payment of £750 for the distress caused to Ms P and her family because of the failings.

Organisation we investigated

The Royal Wolverhampton Hospitals NHS Trust

Poor complaint handling by NHS trust caused distress

Miss A complained about the communication of her cancer diagnosis and the way the Trust dealt with her complaint about this.

What happened

Miss A complained that the Trust took too long to tell her about her diagnosis of cancer and incorrectly told her that she would be contacted before the follow-up appointment if her results were abnormal. She was naturally very upset to be told she had cancer at her follow-up appointment, especially when she had believed that she would be contacted in advance if the results were abnormal.

Miss A also complained that the Trust's complaint handling was poor. She was unhappy with the first response to her complaint because the Trust did not say how it would prevent patients from being given incorrect information about how they would receive test results in future. Miss A did not receive a full response to her second letter of complaint for seven months, after she had pursued this repeatedly and been given conflicting information about how her complaint was being dealt with. This caused significant anger, frustration and distress to Miss A.

What we found

The Trust could have given Miss A her diagnosis more quickly but we felt that the time this took was not unreasonable and would not have adversely affected her prognosis. We did not uphold this part of the complaint.

The Trust had discussed with staff the fact that Miss A had been given incorrect information about how she would receive her results but it did not explain this well to Miss A in its responses to her complaint. We agreed with Miss A that the Trust's complaint handling was not acceptable and we upheld this part of the complaint.

Putting it right

The Trust paid Miss A £250 in recognition of the distress caused by its poor complaint handling. It also wrote to Miss A to apologise and to say how it would prevent similar problems from happening in future.

Organisation we investigated

Royal Liverpool and Broadgreen University Hospitals NHS Trust

Concerns about maternity care after child birth

Ms B complained that after giving birth to twins, there was a delay in diagnosing she had a hernia, and she was wrongly told she had retained products of conception (parts of the placenta left in the womb after childbirth). Ms B said that that this resulted in her suffering significant pain, stress and depression.

What happened

Ms B gave birth to twins by emergency caesarean section in the spring of 2012. Four months later she was told she had retained products of conception, after an ultrasound scan. She had a surgical procedure called evacuation of retained products of conception (ERPC). When the tissue that was removed during the ERPC was analysed, it was found that she had a fibroid, not retained products of conception. Ms B was also found to have a hernia at the site of her caesarean section scar. She had surgery to repair the hernia the following month. Ms B complained to the Trust about a number of matters, including a delay in diagnosing the hernia, and wrongly being told that she had retained products of conception when she in fact had a fibroid.

What we found

Ms B's care was managed appropriately. We found that appropriate investigations were carried out into the appearance of Ms B's caesarean scar, and the diagnosis of an incisional hernia was made at a reasonable time. It was reasonable to assume that Ms B had retained products of conception based on what was seen on the ultrasound scan, and that it would not be possible to identify that this was actually a fibroid until the tissue was removed and examined. We did not uphold the complaint.

Organisation we investigated

West Suffolk NHS Foundation Trust

Summary 50/March 2014

Patient's death from deep vein thrombosis could have been avoided

A GP practice failed to properly investigate an older woman's symptoms over two appointments, or refer her for further tests. If it had, her death could have been avoided.

What happened

Mrs G suffered a deep vein thrombosis (DVT) in late 2011. She then took blood thinning drugs for six months.

In summer 2012 Mrs G telephoned the Practice because her left ankle was swollen. She was seen that day by Dr A, who asked for advice from Dr B. Neither doctor felt that Mrs G's symptoms were a sign of DVT.

Three weeks later, Mrs G returned to the Practice. Her left ankle was still swollen. Her usual GP, Dr C, examined her but again felt that Mrs G's symptoms were not a sign of DVT. Dr C told Mrs G to return for a follow-up appointment in two weeks. Mrs G died at home one week later.

What we found

At both appointments the GPs who saw Mrs G failed to follow the relevant medical guidelines on investigating a possible DVT. They also failed to investigate her symptoms properly. We decided that, on balance, Mrs G's death could have been avoided.

Putting it right

The Practice accepted our recommendations. As a result it completed an action plan that explained how it will comply with the relevant medical guidelines for DVT. It also explained how the doctors involved had learnt from the complaint and what action they had taken to improve their practice as a result of it. They provided Mrs G's relatives with evidence of what they had learnt from the complaint and apologised to them.

Organisation we investigated

A GP practice

Neglect of man's basic needs in hospital and poor communication led to confusion about what was happening

Mrs B complained about the care provided to her husband in hospital over an eight and a half month period leading to his death.

What happened

Mr B was admitted to hospital with a broken arm in mid-2011. He had underlying medical conditions, so discharge planning took some time. Mr B deteriorated while he was in hospital and developed an infection that led to his death in spring 2012. Mrs B, his wife, complained about several aspects of his care, including physiotherapy for his mobility, lack of discharge and poor communication with her and her husband and between the members of the clinical team. She said she had been made to feel her husband's deterioration and death were her fault.

What we found

The Trust had on the whole responded reasonably to Mrs B's complaints about care, discharge planning, and communication. Where failings had been identified, the Trust had addressed these during its handling of the complaint. However, one part of the complaint had not been addressed regarding Mr B's final diagnosis and how this was communicated to Mr and Mrs B.

Putting it right

The Trust wrote to Mrs B to apologise again for her and her husband's overall experience, the confusing communications around Mr B's diagnosis, and that some of the doctors looking after Mr B at the time of his death still thought he had a condition that he did not have.

Organisation we investigated

Lancashire Teaching Hospitals NHS Foundation Trust

GP referral for baby boy was too slow

Ms A complained about how long it took her GP Practice to make a hospital referral for her son, leaving him without treatment when he was very unwell. She also raised a separate concern about prescriptions being wrong.

What happened

Ms A's baby son had been vomiting and had reflux for some weeks after his birth. She took him to see his GP and although the GP decided to refer him to a paediatrician, the Practice did not refer the case until eight weeks later.

The Practice did not prescribe special milk recommended by the hospital Trust for the baby's allergies. It also prescribed a different cream than was listed by the paediatrician. The Practice was also a little slow in prescribing an anti-acid medication.

What we found

The hospital referral was too slow and this caused distress to the family and discomfort for Ms A's baby son. Although the Practice apologised for this and explained how it will avoid a similar situation in future, we felt that a financial payment was justified to acknowledge the distress caused and the frustration for Ms A in having to chase this up.

The Practice did not explain properly why the cream it prescribed was different to that requested by the paediatrician, and we asked it to apologise.

Its actions in relation to the other prescriptions were reasonable, and there was no evidence that the Practice did not act on correspondence from the hospital once it received it.

Putting it right

The Practice paid Ms A £500 to acknowledge the distress and frustration caused by the eight-week delay in making her son's hospital referral and the fact that she had to chase this up, and for prescribing an alternative cream in place of the one requested by the specialist. It also apologised for this.

Organisation we investigated

A GP practice

Delay by dentist in referring patient to hospital caused unnecessary pain and distress

Mr T had a lump in his mouth. He visited the dentist, who said that he would refer Mr T to a specialist. However, the dentist failed to send the referral form. This led to delays in Mr T being seen by a specialist. He was subsequently diagnosed with cancer.

What happened

Mr T and his dentist agreed that the lump in Mr T's mouth was suspicious and should be seen by a specialist. The dentist failed to follow guidelines and did not make the referral correctly.

Mr T contacted the dentist again after five weeks because he was finding it difficult to eat and he had not received an appointment to see the specialist. The dentist then sent a routine referral to the hospital. Mr T received an appointment but it was two months away. As his symptoms were becoming worse and the hospital could not bring forward the appointment without contact from the dentist, Mr T visited the dentist again. This time an urgent referral was made and he received a hospital appointment soon after. Following tests, Mr T was diagnosed with a cancerous tumour.

What we found

The dental records were of a poor standard and did not record findings about Mr T's clinical presentation or symptoms. However, from the records that were available, Mr T's account and the eventual diagnosis, we were able to state that on the balance of probabilities, the dentist should have made an urgent referral to a specialist under National Institute for Health and Care Excellence (NICE) guidelines.

There were failings in the way the dentist dealt with the referrals. He simply did not send the first referral. The second referral asked for a routine appointment. This was not in line with relevant guidelines for suspected cancer.

These failings resulted in a delay of ten to 11 weeks in Mr T seeing a specialist. It is likely, therefore, that his diagnosis of cancer would have been made earlier. We found that Mr T suffered unnecessary pain and distress because of the failings by the dentist.

Putting it right

The dental Practice acknowledged the failings in the delayed urgent referral and apologised to Mr T and paid Mr T £2,500 in recognition of the failings and the pain and distress he suffered. It also formulated an action plan to address the failings around the poor record keeping.

Organisation we investigated

A dental practice

Hospital delayed transferring an older patient for X-ray after fall

Mr L complained that his mother, Mrs L, had a fall in hospital due to a lack of supervision. He also complained that staff failed to diagnose the resulting fracture in a timely manner and this caused additional suffering and damage. Furthermore, Mr L complained that his mother was transferred in a taxi rather than an ambulance.

What happened

Mrs L was admitted to hospital and, around two weeks after her admission, fell early one morning. She was seen by a doctor early in the morning and mid-morning and again in the evening and, on each occasion, the plan was to provide pain relief and review her again if her pain continued.

In the early hours of the following morning, Mrs L was seen by a doctor again and a decision was made to transfer her to A&E so that she could have an X-ray. Mrs L was transferred by taxi and an X-ray revealed that she had a fractured neck of femur.

What we found

The Trust completed appropriate risk assessments and could not have predicted or prevented Mrs L's fall. However, following clinical advice, we found that the medical staff should have had a higher level of suspicion about a fracture and she should have been transferred for an X-ray after the mid-morning review. Mrs L should not have been transferred in a taxi.

This caused Mrs L avoidable short-term pain and distress.

Putting it right

The Trust acknowledged and apologised for the failings we identified in relation to the delayed transfer for an X-ray following Mrs L's fall. It also acknowledged that Mrs L should not have been transferred in a taxi and apologised for this. It paid Mrs L £250 in recognition of the short-term distress and pain she experienced.

Organisation we investigated

South Essex Partnership University NHS Foundation Trust

Trust failed to apologise for patient's six-hour wait in A&E without food or drink

After he arrived in A&E with an eye infection, Mr B was not offered food or drink. He also complained that staff were rude to him. The Trust's complaint handling did not address his complaint.

What happened

In autumn 2012 Mr B went to A&E with an eye infection and was left for six hours in a cubicle without being offered food or drink until his partner arrived to help him. He complained that staff were rude and unhelpful. When he was eventually transferred to the medical assessment unit, he again encountered a rude and unprofessional attitude from one of the nurses.

The Trust did not dispute Mr B's account of what had happened and apologised for his experience in the medical assessment unit. However, it did not provide an apology or any other remedy for his experience in A&E.

What we found

We accepted that Mr B had a poor and uncomfortable experience in A&E and that the Trust's complaint response on this issue was inadequate and would have added to Mr B's frustration.

Putting it right

The Trust apologised to Mr B for his poor experience in A&E. It paid him £150 for the discomfort and frustration he had experienced in the emergency department, and the degree to which the poor complaint handling compounded this.

Organisation we investigated

Croydon Health Services NHS Trust

No evidence of mistake during brain surgery

Mr A developed a loss of sensation in his hand. He believed this was caused by an anaesthetist failing to protect his arms while he was having brain surgery.

What happened

Mr A had brain surgery in 2011. After the surgery, he began to lose sensation in two of his fingers. Mr A was later referred to a hand specialist at a different organisation. He had treatment but this did not resolve the problem. Mr A was told the damage to his hand could only be repaired by reconstructive surgery.

Mr A complained that the permanent damage to his hand was caused during his brain surgery. He believed that his arms were not protected by the anaesthetist. Mr A told us that the Trust had not acknowledged its mistake or provided treatment for this injury. Mr A is no longer resident in the UK and is not entitled to ongoing NHS care so he wanted the Trust to provide the necessary treatment or pay for him to have private surgery in his own country.

What we found

There was no evidence that a mistake was made during Mr A's surgery. The records confirmed that Mr A's arms were correctly protected while he was under anaesthetic. The Trust had provided a reasonable explanation about what happened in response to Mr A's complaint.

It was very unlikely that Mr A's hand condition resulted from his brain surgery because there were other more likely explanations for his condition.

We did not uphold this complaint.

Organisation we investigated

Plymouth Hospitals NHS Trust

No evidence that GP failed to diagnose child's fracture

Mrs K wanted a GP to acknowledge that he should have sent her daughter for an X-ray.

What happened

Mrs K and her husband were on holiday in England when her daughter fell and hurt her shoulder. They went to a local GP who said she had a sprained shoulder. Four days later, as she was still in pain, they went to A&E. The hospital did an X-ray and diagnosed a fractured collar bone. Mrs K complained that the GP failed to send her daughter for an X-ray and made the wrong diagnosis. She did not agree with the GP's account of the consultation and said the medical notes were not accurate.

What we found

We looked at the evidence in the GP's records and concluded that he had given appropriate care. Although we acknowledged that Mrs K disagreed with the information in the records, there was no independent evidence to support her view. There were insufficient grounds for us to uphold her complaint.

Organisation we investigated

A GP practice

Delay in prescribing medication caused distress

Mr Q, who had epilepsy and other medical conditions, experienced a delay in receiving his epilepsy medication when he went into the prison.

What happened

Mr Q had been receiving epilepsy medication as well as a particular painkiller. When he went to prison, he did not have these medications with him and the healthcare team at the prison, provided by Care UK, did not have details of his medical conditions. It took several days for this to be verified with Mr Q's community GP. When details of Mr Q's conditions were received, he was prescribed epilepsy medication.

The prison GP decided that the painkiller he was receiving was not the best one for Mr Q's condition so he prescribed a different painkiller instead.

Just over a week after Mr Q received his epilepsy medication, he had two epileptic seizures. Mr Q said that as a result of these seizures he injured himself.

What we found

The prison healthcare team should have made sure that it obtained details of Mr Q's epilepsy medication more quickly, or should have given Mr Q a temporary supply of this medication while it was waiting for the details of his medical conditions. This medication is very important for epilepsy sufferers and without it Mr Q was at risk of suffering seizures. This clearly caused Mr Q anxiety because he was worried about having a seizure.

However, the seizures that Mr Q suffered were more than a week after the medication was prescribed, so we did not find that the delay in the medication being prescribed had caused the seizures.

We said that the side effects of the painkiller he had been receiving could have worsened Mr Q's conditions so the healthcare team was correct to say that this was not the best painkiller for Mr Q. It was appropriate that it prescribed a different painkiller.

Putting it right

Care UK agreed to take action to show what steps it will take to make sure that the delays in providing Mr Q's medication are not repeated, and have apologised to Mr Q.

Organisation we investigated

Care UK - North East Offender Health

Trust failed to diagnose and treat child's epilepsy

Miss K complained that the Trust failed to investigate her daughter J's symptoms, and this led to a delay in the diagnosis and treatment of her epilepsy. Miss K said that J was only diagnosed and treated 11 months later at another hospital.

What happened

J saw a consultant at the Trust in late 2008. He noted that J had been having '*fits*' and made an appointment to see her four months later. The consultant saw J again in the spring of the next year. Test results showed that J had epilepsy but the consultant did not tell Miss K about the diagnosis, investigate the cause of J's epilepsy, refer her for further assessment, or treat her. Miss K only discovered her daughter had epilepsy when she saw doctors at another hospital later in the year. J immediately received treatment. No cause has yet been found for her epilepsy.

What we found

The consultant failed to carry out timely investigations into J's symptoms. When he carried out the investigations (which showed J had epilepsy), he failed to treat her, arrange a scan to identify the cause of her epilepsy, or refer her to a child development centre for assessment. While the consultant explained that J's parents told him not to start treatment, we found no evidence that any such conversation took place. Furthermore, the consultant should have explained to Miss K the importance of her daughter having a scan. He did not. We found that in the short term (up to 12 months), J's development was affected by the delay in treatment. However, her ongoing development issues are most probably caused by the underlying cause of her epilepsy, not the errors of the Trust.

Putting it right

The Trust has apologised to Miss K, and has paid her £1,000. The consultant agreed to share what he has learnt from this case with his colleagues at the Trust, and Miss K.

Organisation we investigated

Mid Essex Hospital Services NHS Trust

Hospital failed to treat patient appropriately when his condition became unstable in operating theatre

Mr A had a cardiac event after being anaesthetised for surgery. He was not treated appropriately and the hospital failed to acknowledge failings in his care.

What happened

Mr A went into hospital for surgery on his shoulder. Shortly after he was anaesthetised, he suffered a problem with his heart. The cardiac arrest team was called and Mr A was given cardiac compressions and drug treatment. Fortunately he made a rapid and full recovery and tests showed there was no ongoing problem with his heart.

Mr A believed he had suffered a cardiac arrest and asked the hospital for an explanation of what had happened to him. He thought that the event might have been linked to the fact that he had recently been taking tablets to lower his blood pressure. The hospital said that his blood pressure and heart rate dropped dangerously low but he did not suffer a cardiac arrest. Mr A was unhappy with the hospital's explanation of events and continued to believe he had suffered a cardiac arrest and that the hospital had caused this. This left him fearful about future surgery.

What we found

We looked at the clinical records and took independent clinical advice. There were significant shortcomings in the care Mr A was given. The preoperative assessment the consultant anaesthetist carried out was below expected standards but there was nothing to suggest that this had any bearing on what happened in theatre. The clinical records about Mr A's time in theatre were poor, so it was difficult to be certain about what actually happened. However, it was clear that the actions taken by the consultant anaesthetist to treat Mr A when he became unwell in theatre were inappropriate. This put Mr A's life at risk and left him with some short-term pain and discomfort. When Mr A complained, the hospital failed to give him complete and fair explanations of what happened or an apology for the shortcomings in care.

Putting it right

The hospital acknowledged the failings identified and apologised to Mr A for the injustice which resulted. The hospital also paid him £500 for the distress he suffered as a result of the poor complaint handling. We asked the consultant anaesthetist involved in Mr A's care to discuss our report with his appraiser and we shared our report with his responsible officer.

Organisation we investigated

BMI The London Independent Hospital

Unnecessary kidney surgery led to bowel damage and infections that plagued patient for final 20 months

Failure to accurately diagnose recurrent ovarian cancer led to surgery to remove Mrs P's kidney when she should have received chemotherapy.

What happened

Four years after undergoing treatment for ovarian cancer, Mrs P had some routine scans and blood tests, which doctors thought were suggestive of a new kidney cancer. They operated to remove Mrs P's kidney and this led to bowel damage. After the operation, tests showed that Mrs P's cancer was recurrent ovarian cancer. Mrs P received, and responded well to, palliative chemotherapy (treatment given to relieve symptoms rather than cure), but was plagued by infections at the site of the kidney surgery for the rest of her life. Mrs P's daughter, Miss P, complained that her mother received inadequate care and treatment from the Trust. She said that her mother might have had a longer life and that her suffering could have been avoided.

What we found

The Trust failed to provide an accurate diagnosis or effective treatment. The doctors should have done more to obtain an accurate diagnosis before operating to remove Mrs P's kidney. Also, the surgeon who carried out the kidney surgery should have recognised that there would be a high risk of bowel damage and done more to avoid it. An accurate diagnosis would have avoided surgery and led to Mrs P getting chemotherapy earlier. Although we could not say that she would have lived longer if this had happened, she would not have suffered the bowel damage that led to undignified suffering. The Trust also did not investigate Miss P's complaint thoroughly.

Putting it right

The Trust acknowledged and apologised for its failings, and paid Miss P £4,000 for distress. It also agreed to put together action plans showing learning from this complaint.

Organisation we investigated

Walsall Healthcare NHS Trust

Podiatrists' failure to identify circulation problems did not lead to patient's death

Mr S complained that podiatrists did not identify his wife's circulation problems and refer her to a vascular consultant quickly enough. He also complained that his wife did not get appropriate care when she was admitted to hospital with a dying foot.

What happened

Mrs S was under the care of podiatrists at Derbyshire Community Health Services NHS Trust for a foot ulcer. Her foot symptoms worsened, and eventually the podiatrists referred her to the acute hospital to see a vascular doctor.

A few months later, Mrs S was admitted to the acute hospital (Chesterfield Royal Hospital NHS Foundation Trust) with a dying foot and was told she would need to have her leg amputated. She was not fit for surgery immediately and needed treatment to get her prepared so that she had a better chance of surviving the operation. The surgeons got her better prepared for the surgery she needed, but Mrs S developed pneumonia and died before it could be done. Mr S complained that there was a delay in referring his wife to the acute hospital and that this may have ultimately resulted in her death.

What we found

The podiatrists should have identified Mrs S's circulation problems sooner than they did. The delay was a failing in the podiatry service, but it did not result in Mrs S's death. This is because her circulation problem would have been as bad as it was when it was eventually discovered, even if it had been discovered some weeks sooner.

When she was admitted to hospital with a dying foot, surgeons treated her appropriately.

Putting it right

We made no recommendations for improvements because we were satisfied that the action the podiatry department had taken before the complaint came to us was adequate.

Organisations we investigated

Chesterfield Royal Hospital NHS Foundation Trust

Derbyshire Community Health Services NHS Trust

Poor treatment led to irreversible damage to teeth

Failings in dental care over two years resulted in irreversible damage to a patient's teeth.

What happened

Mrs E had gone to her dentist regularly for many years. In 2010 she went to the dentist in pain and X-rays showed that she had developed decay in two of her molar teeth. The dentist then treated both these teeth. Mrs E continued to have problems with her teeth and over the next two years had more treatment. Finally, she was referred to a dental hospital, where it was found that her two molar teeth were so badly decayed that they could not be restored.

What we found

The dental Practice had failed to treat all of the decay showing on Mrs E's X-rays, so it became worse over time. If her dentists had treated the decay properly, her teeth would not have deteriorated to the point where they were beyond restoration.

The dental Practice had also not handled Mrs E's complaint properly.

Putting it right

The Practice acknowledged the failings we identified, apologised to Mrs E and prepared an action plan to prevent similar failings in future. It also paid her £3,000 compensation in recognition of the impact the damage to her teeth had had on her and the anger and upset caused by the Practice's poor complaint handling.

Organisation we investigated

A dental practice

Doctor failed to tell dying patient his cancer had spread

Mr B's daughter, Ms H, complained that, although doctors knew that her father's prostate cancer had spread, they did not tell him about it until the day before he died. She also complained that his pain was not properly controlled during a hospital admission, and that he was not offered support to help him manage at home.

What happened

Mr B was diagnosed with prostate cancer and started on hormone treatment for it. He was unwell and his GP arranged for him to be admitted to hospital. While he was there, Mr B's oncologist arranged for a scan of his back because he was suffering a lot of back pain. The scan showed his prostate cancer had spread into his spine. Mr B was discharged home, but became increasingly unwell. He was not assessed for a care package to help him manage at home, despite his obvious frailty. The following month, he was admitted to hospital again. He and his family were then told that his cancer had spread. Mr B died the next day.

What we found

The consultant in charge of Mr B's care should have told him his cancer had spread before discharging him from hospital. Also, staff should have given him better pain relief. Had they done so, Mr B's pain might have been better controlled, and he and his family would have known that his cancer had spread, which might have enabled them to get more help at home for him.

Mr B was clearly very frail, so staff should have assessed whether he needed a home care package. Had they done so, it is likely he would have been offered appropriate home support. The fact that they did not do this meant Mr B was left without support when he needed it, which was frustrating and distressing for his daughter to see. She now has to live with the knowledge that more should have been done for her father.

Finally, the Trust's response to Ms H's complaint was inadequate. This made her frustration and distress even worse.

Putting it right

The Trust acknowledged the failings in Mr B's care and the handling of Ms H's complaint. It paid Ms H £1,250 as compensation for the injustice she suffered, and created an action plan to show it had learnt from the failings identified and made improvements to stop them happening again.

Organisation we investigated

George Eliot Hospital NHS Trust

Healthy ovary removed unnecessarily

Mrs F (who was in her 30s) complained that a gynaecologist removed a healthy ovary after failing to adequately assess her and plan appropriate treatment, leading to distress and worry.

What happened

Mrs F was referred to the gynaecologist by her GP after a long period of abdominal pain. The gynaecologist did not fully assess Mrs F and instead chose to operate on the basis of an inconclusive ultrasound scan that suggested there was an ovarian cyst and blocked fallopian tube. During the operation he removed the ovary and fallopian tube, despite there being no evidence of a cyst or a blockage. Mrs F was still in pain after the procedure and sought a second opinion. She was told by a second gynaecologist that there had been nothing wrong with her ovary and it should not have been removed. During the complaint process, the hospital told Mrs F that the ovary was removed because she had insisted on it, something which is denied by Mrs F.

What we found

The gynaecologist was justified in performing an investigative operation on Mrs F, but it was clear from photographs taken during the operation that the ovary was healthy. At this point, the gynaecologist should have stopped the operation. Instead, he removed a healthy organ with no reason. There was no evidence that Mrs F had specifically requested the ovary's removal and, even if she had, there were no grounds for the gynaecologist to remove a healthy organ at that time. Mrs F did not contract varices from the operation as she had claimed. However, this did not detract from the fact that she had a healthy organ removed unnecessarily, which caused her considerable distress and worry. So we upheld her complaint.

Putting it right

The hospital apologised to Mrs F and paid her £5,000 in compensation. We also recommended that the hospital produce an action plan to address the failings identified.

Organisation we investigated

Ramsay Healthcare UK – Springfield Hospital

Older woman died on toilet at home after doctor discharged her without performing abdominal examination

Mrs T was taken to hospital after falling ill. A doctor in A&E discharged her, but did not examine her abdomen. She died at home from perforated diverticulitis.

What happened

Mrs T, who was in her late 90s, fell ill at home and was seen by her GP. She became unwell overnight and was taken to hospital by ambulance. After arriving at hospital, she was examined by a nurse and later a doctor. The doctor discharged her without examining her abdomen. She later died of perforated diverticulitis on the toilet at home in her granddaughter Miss T's arms. Miss T complained to the hospital and said that the Trust had failed to provide an adequate response and had tried to '*cover up*' its failings.

What we found

We found some failings in the way nurses assessed Mrs T. We also found that the doctor should have examined Mrs T's abdomen in line with established good practice. As a result of the doctor's failure to examine her, Mrs T was discharged before further tests could be carried out and before her diverticulitis could be diagnosed. As a result, she died at home, on the toilet, rather than in hospital. This was distressing for Miss T. We found, however, that the Trust had investigated Miss T's complaint, during which it said Mrs T was not assessed as well as she should have been. Accordingly we found no evidence that the Trust tried to '*cover up*' what had happened.

Putting it right

Following our report, the Trust agreed to acknowledge and apologise for its failings and put together an action plan that showed learning from its mistakes so that they would not happen again. We recommended the Trust pay £500 in compensation for Miss T's distress.

Organisation we investigated

East Kent Hospitals University NHS Foundation Trust

GP practice failed to urgently refer patient

A man who had prostate problems was not referred to a urology department quickly enough when test results showed he should be referred urgently.

What happened

Mr R went to his GP Practice at the end of 2007. The GP carried out a physical examination and a blood test to measure his prostate-specific antigen (PSA) levels, which were normal for his age. Mr R went back to his GP in mid-2008, spring 2010, spring 2011, and twice towards the end of 2011. During this time, the GP carried out various examinations and tests because Mr R had difficulty urinating and some discomfort. The PSA test results showed that Mr R's levels were rising and high for his age. The GP prescribed antibiotics at the mid-2008 appointment and took a 'watch and wait' approach.

The GP referred Mr R to a urologist (a specialist in problems of the kidney, bladder and genitals) in late 2011, but did not refer him under the two-week 'wait pathway' (the national guideline for how long it should take to see a specialist). Mr R was diagnosed with prostate cancer in February 2012 by a urology clinic and had to have radiotherapy and hormone treatment.

What we found

Mr R's urgent referral to a urologist should have been made as early as spring 2010 because his PSA levels continued to rise and were high for his age. When he was referred in late 2011, it was a routine referral. Although we cannot say on balance that his treatment options were limited because of this, Mr R now has to live with the knowledge that his chances of recovery have been affected for the worse.

Putting it right

The surgery acknowledged and apologised for the failings identified and put together an action plan that showed how it had learnt from its mistakes so that they would not happen again. We also recommended that the GP reflect on his actions in the case and the lessons for him personally.

Organisation we investigated

A GP practice

Delay in diagnosis of rare syndrome in older woman

Mrs B's daughters complained that there was a lack of communication about the aggressive form of breast cancer that their mother had, a delay in diagnosis of what was causing her rapid decline, poor care and treatment provided in hospital and poor complaint handling.

What happened

Mrs B had treatment for an aggressive form of breast cancer and following remission began to deteriorate rapidly. After the eventual diagnosis of a rare syndrome she died. Her daughters complained about: the lack of information provided to their mother about her cancer and treatments; lack of investigation following remission when their mother began to deteriorate and was admitted to hospital; delay in getting their mother to an acute hospital for investigations, diagnosis and treatment; poor care in two of the hospitals she stayed in during this time; lack of diagnosis of reoccurring cancer and subsequent poor complaint handling when both daughters made complaints in their own right. The daughters felt that if their mother had been diagnosed earlier, she could have received treatment and might not have died when she did.

What we found

There were failings in the way that the Trust responded to complaints about: information provided to Mrs B about her initial diagnosis; delays in arranging an MRI scan; monitoring of nursing care to ensure improvements; poor communication about discharge; and the provision of incontinence products.

We consider that, as a result of this, there is no documentation to support the doctor's assertion that Mrs B and her family were fully informed about her initial diagnosis and treatments available. There were some delays in arranging an MRI scan and there is a lack of reassurance that monitoring is in place for the actions taken to improve matters as a result of this complaint.

However, given her rapid deterioration and condition, the outcome for this patient would not have been changed by the failings found and delay in diagnosis.

Putting it right

The Trust has acknowledged the failings identified and has apologised, paid £500 to each of the complainants for distress, and completed an action plan dealing with the failings found.

Organisation we investigated

Colchester Hospital University NHS Foundation Trust

Reasonable overall care, but poor complaint handling

A patient was given reasonable overall care by a hospital and nursing home, although doctors delayed acting on the patient's low oxygen levels.

What happened

Mrs L was admitted to a hospital trust at the end of 2011 for stroke rehabilitation. Six months later she was discharged to a care home. However, Mrs L was readmitted to the Trust after five weeks at the care home. She died a week later.

Mrs L's daughters, Mrs D and Mrs R, complained that the Trust did not provide adequate care and treatment for their mother during her first admission. They said that she was not in a fit state to be discharged, that doctors delayed diagnosing her stomach ulcer and treating her chest condition, that they failed to diagnose or treat a further stroke, and that Mrs L received inadequate care for Clostridium difficile (also known as C difficile) and inadequate physiotherapy.

Mrs D and Mrs R also complained that the care home provided inadequate care for their mother and did not handle their complaint appropriately. They said that their mother's needs were not adequately assessed before she was admitted to the home and that staff were not competent to care for her. They also complained that nurses did not properly administer oxygen and provided poor pressure area care for her, as well as that nurses replaced Mrs L's feeding tube despite instructions that it should only have been done by doctors in hospital. They complained too that the care home described their complaint as '*absurd, idiosyncratic, anecdotal and amateurish*'.

What we found

There was a 12-day delay in the summer of 2012 in doctors taking further action on Mrs L's low oxygen levels. This delay fell so far below the applicable standards that it was service failure. However, the failing had no impact on Mrs L, so we partly upheld Mrs D's and Mrs R's complaint about doctors' failure to treat Mrs L's chest condition. There were no other failings in the Trust's care of Mrs L, which was reasonable overall, so we did not uphold any of the other complaints about the Trust.

We found no failings in the care that the care home provided for Mrs L, so we did not uphold any of Mrs D's and Mrs R's complaints about this. However, we upheld the complaint about the way the home replied to their concerns. We found the care home was not '*being customer focused*' by using such insensitive and dismissive terms to describe the complaint, and this was maladministration.

Putting it right

The Trust wrote to Mrs D and Mrs R within one month of the final report, acknowledging the failing in care we had identified. The Trust has explained what action it has taken, or will take, to prevent similar failings from happening in the future.

The care home has written to Mrs D and Mrs R to apologise for the way it responded to their complaint. It has acknowledged and apologised for the impact that this had on Mrs D and Mrs R.

Organisations we investigated

A care home

George Eliot Hospitals NHS Trust

GP failed to consider that cancer might have come back

Ms N complained about a consultation with a GP who failed to act on what she said about her symptoms and send her for investigations. Ms N also complained about the GP's attitude at the appointment.

What happened

Ms N (who previously had breast cancer) consulted the GP about worsening back and shoulder pain since taking a shower five days before. The GP diagnosed muscle strain and advised painkillers. Ms N also mentioned a cough she had had for a year. The GP treated her for acid reflux (when acid comes up the gullet from the stomach) which can cause a persistent cough. She advised Ms N to come back if her symptoms did not get better. Ms N did not return but went to A&E with worsening back and shoulder pain three months later. Chest X-rays at that time were clear, but shortly afterwards another GP at the Practice referred Ms N to the hospital in view of her continuing cough. Tests revealed that Ms N's breast cancer had come back.

What we found

The GP examined Ms N appropriately and advised her correctly on follow up. However, she did not give enough consideration to Ms N's past history of cancer. She should have looked more thoroughly for worrying signs and symptoms of this returning. She should also have sent Ms N for a chest X-ray in view of her history and her continuing cough. National Institute for Health and Care Excellence (NICE) guidance says people with a persistent cough for longer than three weeks need an urgent X-ray. The GP's diagnosis of acid reflux was not supported by what she recorded in Ms N's notes. We upheld this aspect of Ms N's complaint but we did not uphold the complaint about the GP being dismissive at the consultation, which had lasted 11 minutes.

Putting it right

The GP has apologised to Ms N and has acknowledged the failings we identified. She also agreed to draw up an action plan to show how she will avoid such failings in future.

Organisation we investigated

A GP practice

Trust failed to take appropriate action to diagnose woman's heart attack

When Mrs P experienced back pain, doctors failed to diagnose that she had had a heart attack.

What happened

Mrs P became unwell in late 2011 with severe pain between her shoulder blades and an ambulance was called. A paramedic arrived first, followed by an ambulance crew. At that time Mrs P had no chest pain or any symptoms consistent with a heart attack. She was taken by ambulance to A&E at South London Healthcare NHS Trust where she was diagnosed with likely musculoskeletal pain and sent home with painkillers.

Mrs P remained unwell and went to her GP who referred her to the Trust for an ECG. This was carried out in early 2012 when she was diagnosed with cardiomyopathy and given medication.

What we found

Mrs P showed no signs of having had a heart attack, and so we found no fault with the initial assessments made by the paramedics and ambulance staff.

It was likely that Mrs P had indeed suffered a heart attack the day she went to hospital, but no tests that might have diagnosed this were conducted in A&E. This could have had very serious consequences for Mrs P, but the Trust failed to identify or acknowledge the risk to her.

Putting it right

South London Healthcare NHS Trust has apologised and paid compensation of £1,250. It has put a plan in place to learn lessons from the failings and make sure they do not happen again.

Organisations we investigated

London Ambulance Service NHS Trust

South London Healthcare NHS Trust

Trust failed to arrange CT scan on baby promptly

Mrs D's baby was admitted with a repeated twitch. Although the Trust provided reasonable care and transferred her to a specialist unit appropriately, it did not arrange for a CT scan as quickly as it should have done.

What happened

Mrs D's baby was admitted to the Trust with a repeated twitch just after midnight. Other symptoms suggested the baby might have suffered a non accidental injury and social services were informed. Mrs D was also concerned about the way one of the doctors had spoken to her once the suspicion of a possible non accidental injury was raised.

Following a CT scan the following morning the baby was transferred to a specialist unit at another hospital, where she was diagnosed as having had a bleed to the brain (an aneurysm). This ruled out any possible non accidental injury.

What we found

We decided that while the Trust did provide reasonable care and treatment for the baby, it should have identified the need for the CT scan more quickly. This should have been carried out during the night, rather than left to the next morning. We found, however, that the delay in the CT scan did not affect the outcome for the baby, who fully recovered.

We decided there was not enough evidence to establish any failings in the way the doctor had spoken to Mrs D.

Putting it right

The Trust has apologised for not arranging the CT scan more quickly. We also said it should put an action plan in place to learn the lessons from the failings to make sure they did not happen again.

Organisation we investigated

Burton Hospitals NHS Foundation Trust

Consultant delayed seeing terminally ill patient

Mr N's daughter-in-law, Mrs P, complained that his consultant failed to see him for several days after he was admitted, and that the nursing care Mr N received was inadequate. She also complained that the Trust handled her complaint about this poorly.

What happened

Mr N was admitted to the acute hospital after surgery at a specialist hospital to reduce the size of a brain tumour. His consultant saw him three days after he was admitted, because he was admitted over a weekend when the consultant was not there. In the meantime, Mr N's family contacted the palliative care team for help for him. Mr N died in hospital after deteriorating quickly.

In response to Mrs P's complaint about this, the Trust made several factual errors. For instance, it got the date of Mr N's death wrong. It corrected these errors in a further response after Mrs P pointed them out.

What we found

Mr N's consultant should have seen him on the first day he was available, which was the day before he actually did. Had he done so, he would probably have recognised that Mr N needed input from the palliative care team, and this would have meant Mr N's family would not have had to chase this up themselves.

Mr N received adequate nursing care while he was in hospital. Aspects of his overall experience were poor, but this was because of the unexpectedly rapid deterioration in his condition rather than poor care.

The Trust's initial response to Mrs P's complaint was poor as it contained a lot of errors. However, when she pointed this out to the Trust, it put it right by apologising, explaining how it happened and what it had done to prevent something similar happening again, and by providing a response containing accurate information.

Putting it right

The Trust has acknowledged and apologised for the failing we found and the resulting injustice. It has told Mrs P what it is going to do to learn from the failing we identified and what it will do differently in future to prevent the same thing happening again.

Organisation we investigated

East and North Hertfordshire NHS Trust

Inadequate investigations did not amount to '*cover up*'

Mrs D was diagnosed with breast cancer seven months after having a mammogram that was reported as '*normal*'. She asked the Trust whether anything had been missed on the mammogram but got no response. She complained to NHS England (then a PCT) that the Trust's reluctance to respond made her feel as though they were hiding something. She complained to us, as neither the Trust nor NHS England gave her a clear answer.

What happened

Mrs D had a mammogram and was told that it was '*normal*'. Seven months later she was diagnosed with breast cancer. She asked the Trust whether there had been a mistake in reading the mammogram. The Trust did an Interval Cancer Review, but did not pass the results of this on to Mrs D. This was because the doctor who was going to give them to her misunderstood Mrs D's request and made a mistake when gathering information.

Mrs D complained to NHS England as she had lost faith in the Trust's ability to provide a response. NHS England arranged for an independent review of the mammogram and a meeting to discuss Mrs D's concerns. Mrs D was given the review report at the start of the meeting and told to read it when she got home.

When read in conjunction with what NHS England said to Mrs D about her concerns, the report seemed to suggest that something had gone wrong with the interpretation of the mammogram. Understandably confused, Mrs D complained to us as she wanted a final, clear explanation of what had happened.

What we found

It was understandable that Mrs D felt something was being covered up when the Trust did not respond to her request for further information. However, the fact that they did not respond was due to a misunderstanding and error on the part of one individual. This was unfortunate, but it was not service failure.

To help us decide whether the responses were appropriate, we took clinical advice, which showed that the cancer was visible – with hindsight – on the original mammogram. But the abnormality that could be seen was very unclear and is the sort of thing that is sometimes overlooked.

NHS England initially made good attempts to resolve Mrs D's complaint by arranging for an independent review of her mammograms followed by a meeting to discuss her concerns. However, its good work was somewhat undone when it did not get a copy of the independent review report to give to Mrs D before the meeting. This meant that, when she read the report after the meeting, Mrs D was left with unanswered questions that could have been – but were not – discussed at the meeting. This was upsetting for Mrs D as she continued – incorrectly, but understandably – to believe that an error had been made and covered up.

Putting it right

NHS England wrote to Mrs D, acknowledging the failings identified, and apologising to her for the injustice she suffered as a result of those failings.

Organisations we investigated

NHS England – Leicestershire and Lincolnshire Area Team

University Hospitals of Leicester NHS Trust

Summary 76/March 2014

Due to lack of clear information, patient could not give informed consent before procedure

Ms A complained about the information she received before undergoing some gynaecological procedures. She said that she was not given enough information, in a manner that she could understand, before providing consent. She also complained that one of the procedures was not stopped when she requested this, and about symptoms she experienced afterwards.

What happened

Ms A went to hospital to undergo the procedures to rule out cancer. However, there was confusion from all involved in terms of what she was consenting for, and this was not helped by the fact that Ms A did not receive any of the information leaflets that the Trust said that it sent to her in advance.

What we found

The procedures that Ms A underwent were appropriate and were carried out in accordance with relevant guidance. However, she was not given a clear explanation in advance so that she could provide informed consent. The records of the appointment were not completed fully.

Putting it right

The Trust has apologised to Ms A that she did not understand the procedures that she underwent and that the records do not show that a clear explanation was provided, and for the distress this caused. It has produced an action plan to reassure us that it will record when verbal consent has been provided, and when a patient requests that a procedure be stopped.

Organisation we investigated

Barts Health NHS Trust

Summary 77/March 2014

Different views on reasonable adjustments

Mr K complained that the Practice did not consider his sleep disorder when dealing with him, or help him with his needle phobia and dietary advice. He complained he had not been supported during a crisis.

What happened

Mr K found it difficult to arrange appointments at the Practice because of his sleep condition. He said he needed help with his needle phobia and dietary advice, which had not been given. He also said he had been refused help during a crisis when he called the Practice asking for help and became distressed wanting to self harm.

What we found

We found that the Practice had tried to accommodate Mr K's sleep condition and had made appropriate adjustments. We also found that he had received referrals for his needle phobia and dietary advice after he raised concerns about this. However, we found that the Practice did not take enough action during Mr K's crisis, and a GP should have called him.

Putting it right

The Practice has written to acknowledge and apologise for this and has learnt from what happened.

Organisation we investigated

A GP practice

Trust failed to spot signs of sepsis

When a man was taken to hospital, the signs of sepsis were missed and he died the following day.

What happened

Mr L was taken to hospital from his care home in the early hours of the morning when he became unwell and breathless. He was seen in the emergency department but was assessed as being safe for discharge back to his care home with some antibiotics. Mr L died the following day. His cause of death was recorded as sepsis.

Mr L's wife complained to the Trust and said that if her husband had been admitted for treatment, he might have survived. The Trust told Mrs L that an admission would not have made any difference and that he was discharged appropriately. Mrs L asked us to investigate.

What we found

We found that the Trust did not properly consider all of the clinical information available to them and did not investigate alternative diagnoses. The severity of Mr L's condition and the possibility he had sepsis should have been recognised and Mr L should have been admitted to hospital for treatment. Because Mr L's full diagnosis was not known, we could not say for certain whether his death was preventable. However, Mrs L suffered distress as a result of her husband's inadequate treatment and because it was not possible to say whether or not he might have survived.

Putting it right

The Trust has apologised to Mrs L and has paid her compensation of £2,000. It has agreed to create an action plan addressing the failings we identified.

Organisation we investigated

Harrogate and District NHS Foundation Trust

Trust failed to take action to prevent older woman falling in hospital

On admission, the Trust identified Mrs F as being at high risk of a fall but did not avoid it. This contributed to her deterioration and death in hospital.

What happened

The Trust identified Mrs F as being at a high risk of a fall but it did not put in place a falls risk plan on her transfer to another ward five days later and no discussion about her falls risk took place between the staff. Further, the Trust did not carry out an assessment of falls risk in the second ward. Mrs F then fell while trying to move from the commode to her bed, fracturing her hip and bruising the side of her head. Mrs F's family were not told about the fall and her daughter only found out about it when she visited her mother later that day. Mrs F's condition deteriorated rapidly and she died three days later.

The Trust produced a serious incident requiring investigation (SIRI) report, which concluded that the fall could have been prevented. It did not share this with Mrs F's daughter and the complaint responses did not fully reflect the conclusions of the SIRI report.

What we found

The Trust was not as open as it should have been following Mrs F's fall. The fact that the SIRI report was not shared and its conclusions not fully reflected in the complaint response left the family with unanswered questions.

It was appropriate to leave Mrs F on the commode in privacy, but the Trust failed to take sufficient action to minimise the risk of a fall. There were also failings in communication with the family. The fall was likely to have contributed to her deterioration and death. However, it was not the sole cause and Mrs F received appropriate care after her fall.

Since the time of these events, the Trust has taken action to improve the standard of nursing care, falls risk assessment and care planning, ward leadership and communication with patients and relatives.

Putting it right

The Trust has apologised for failing to take appropriate steps to minimise the risk of the fall. It has also agreed to apologise for not sending the SIRI report to Mrs F's daughter and that its complaint response did not fully reflect the conclusions of that report. It has sent the family the SIRI report and information about all the actions it took as a result.

Organisation we investigated

Kettering General Hospital NHS Foundation Trust

Trust failed to monitor baby appropriately

After a transfer from Leicester Royal Infirmary to Leicester General Hospital, staff failed to monitor Baby B in line with her care plan.

What happened

Baby B was born with Down's syndrome and after her birth, she was transferred to Leicester Royal Infirmary. She was later transferred to Leicester General Hospital but when her condition deteriorated she returned to Leicester Royal Infirmary. Baby B was diagnosed with a serious disease affecting the bowel during the first three weeks of life, and died when she was seven days old.

What we found

Staff failed to carry out planned six-hourly monitoring of Baby B when she was transferred to Leicester General Hospital. However, this failing did not result in a missed opportunity to treat Baby B and her death was unavoidable.

Putting it right

The Trust has apologised to Ms A, Baby B's mother, and has put together an action plan that shows how it has learnt from its mistake so that this will not happen again.

Organisation we investigated

University Hospitals of Leicester NHS Trust

Summary 81/March 2014

Trusts ignored patient's wishes, which led to last six months of life '*wasted just waiting*'

Poor communication between two hospitals led to unreasonable delays in treatment, unnecessary surgery and poor care, which put the patient's health at risk.

What happened

Bedford Hospital NHS Trust diagnosed Mrs C with bladder cancer. It discussed her care with specialists at Cambridge University Hospitals NHS Foundation Trust who recommended chemotherapy. Mrs C opted for surgery to remove her bladder. The Cambridge Trust wanted to carry out a procedure so that Mrs C could start chemotherapy before surgery to remove her bladder. The Bedford Trust said this would be of little benefit to Mrs C. Although Mrs C was clear that she wanted her bladder removed, the hospitals failed to agree on a treatment plan. There were then further delays before the surgery to remove her bladder. Mrs C's condition continued to deteriorate and she later died.

Her family complained about her care and treatment, saying the Trusts did not effectively communicate with their mother about her treatment and the delay in removing her bladder was unreasonable. They said they had not had factually correct answers from the Trusts.

What we found

There was an unacceptable delay in the removal of Mrs C's bladder and doctors failed to listen to Mrs C and respect her choices about her treatment. However, Mrs C's cancer was already so far advanced that the failures we identified would not have affected her prognosis. We also found that there was a failure to refer Mrs C to a community nursing team in a timely way or to provide her with the replacement bags she needed. There were failings in complaint handling in that concerns a doctor raised about the appropriateness of the procedure were not appropriately followed up.

'*We have been emotionally affected by what happened and have been unable to grieve properly. We feel that we lost a member of our family prematurely and that the last six months of our mother's life* [were] *wasted just waiting. No one listened to us or our mother and this left us feeling helpless.*' Mrs C's family

Putting it right

Both Trusts have apologised for their failings. They have agreed to put together action plans that showed they had learnt from their mistakes so that they would not happen again. The Trusts have paid Mrs C's family £1,750 in compensation for the upset and frustration they experienced as a result of the poor care given to their mother.

Organisations we investigated

Bedford Hospital NHS Trust

Cambridge University Hospitals NHS Foundation Trust

Multiple failures in nursing care of older patient

Mr B suffered poor nursing care during a three-week stay in hospital.

What happened

Mr B was admitted to hospital with suspected pneumonia in 2011. He spent three weeks in hospital. While he was there he ate and drank very little and developed a pressure ulcer. Despite tests showing he had MRSA, nothing was done about this for almost two weeks. His son, who visited him at hospital, said he witnessed a nurse giving his father medicine without first checking his identity and handling his tablets without gloves or first washing her hands.

What we found

Nurses did not monitor Mr B's eating and drinking properly or give him the support he needed. Mr B's pressure ulcer became worse during his time in hospital, and nurses did not seek specialist help with this when they should have done. Ward staff repeatedly failed to check Mr B's MRSA test results and a nurse did not follow proper procedure when giving Mr B his tablets.

The Trust's response to Mr B's son's complaint was delayed and did not address all of his concerns.

Putting it right

The Trust has acknowledged and apologised for its failings and has put together an action plan to show how it will prevent these failings happening again. Mr B's son has also received £1,000 compensation.

Organisation we investigated

Norfolk and Norwich University Hospitals NHS Foundation Trust

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