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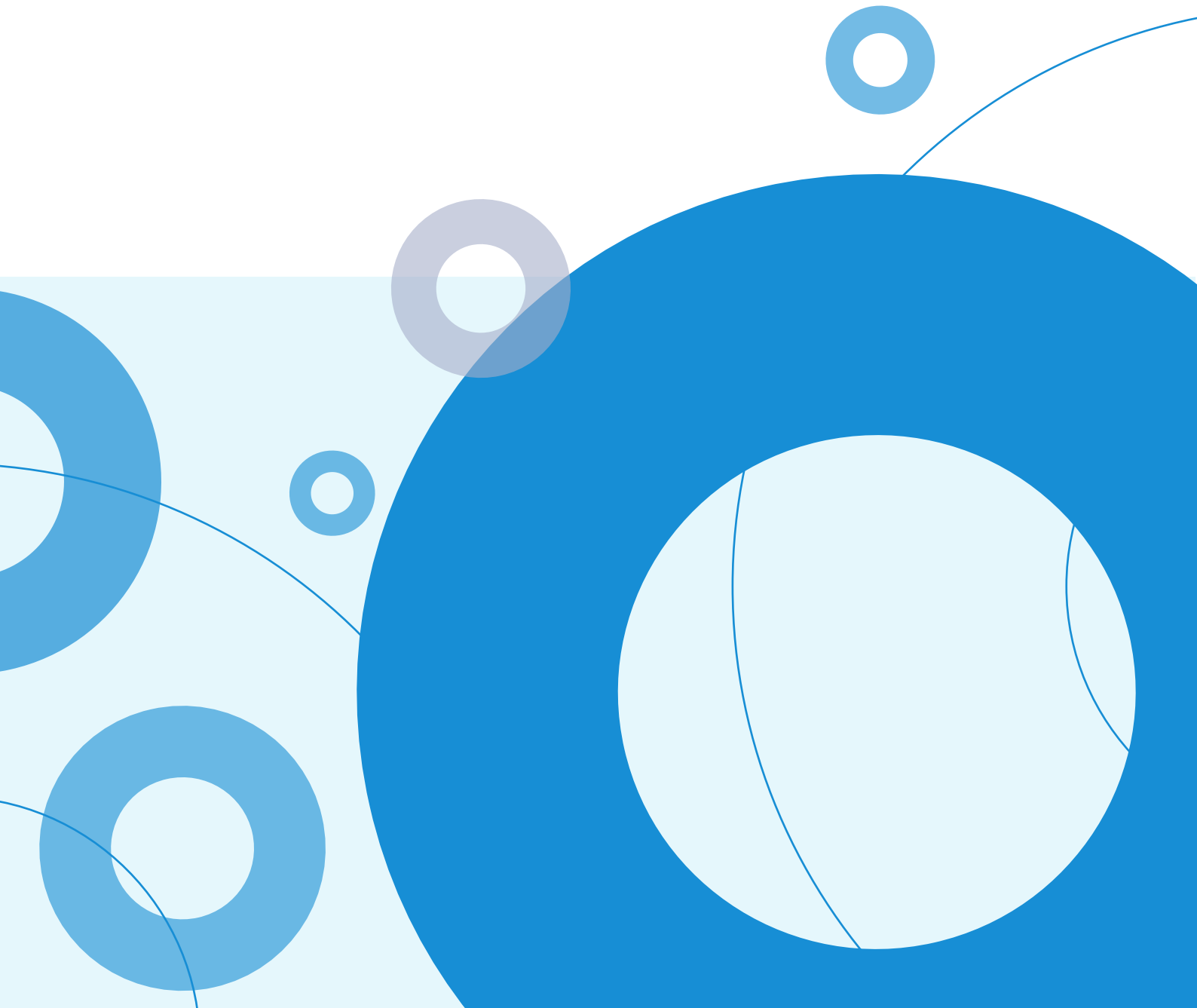
PUBLIC SERVICES OMBUDSMAN FOR WALES

Equality & Human Rights Casebook 2022/23

November 2022



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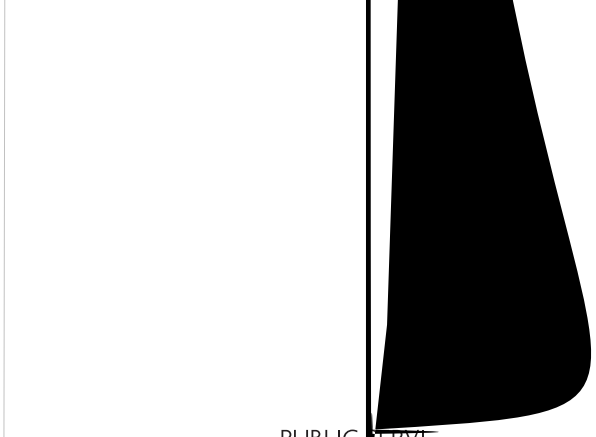
Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

This document is also available in Welsh.



PUBLIC SERVI

Foreword

This is our fourth Equality and Human Rights Casebook.

Much has changed since we first launched this publication in 2020, with the COVID-19 pandemic severely disrupting public service delivery in Wales, in the UK and around the world. However, our approach to equality and human rights issues that we see in our casework has remained unchanged.

We have always been clear that it is not our role to conclude that someone's human rights have been breached, or that they have been discriminated against. That is a matter for the Courts. However, we see in our casework every day that human rights and equality

duties of public service providers may have been engaged. The selection in this casebook focuses mainly on issues around offering reasonable adjustments to disabled people.

Although in most of the cases included in this casebook we upheld the elements of the complaint engaging human rights or equality issues, we also include several complaints that we did not uphold. We believe that this is important to better explain our approach to such cases, as well as to highlight correct administrative practice by the bodies investigated.

This publication focuses on our complaints about public services. However, I would like to take this opportunity to underline that we also embed attention to equality and human rights considerations in our other work.

Last year, we issued our first Own Initiative investigation report, 'Homelessness Reviewed', which raised important human rights and equality issues. The local authorities we investigated - Cardiff, Carmarthenshire and Wrexham - have worked hard to improve services to comply with our recommendations. That included actions to deliver equality and human rights training to homelessness staff and to make their homelessness services more accessible to service users. We continue to work with the 19 authorities that we did not investigate, monitoring progress and improvement throughout Wales to ensure improved services for those who are homeless or at risk of homelessness.

In addition, when we handle complaints about possible breaches of the Code of Conduct we also look at equality issues. Under the Code, councillors must respect equality of opportunity for all people. During 2021/22, we investigated some cases where that part of the Code was breached. For example, in one such case the councillor breached the Code by making comments about another member's hearing impairment and deliberately making it difficult for that member to participate in Council meetings.

We know that there is an ongoing discussion at UK level about the future of the Human Rights Act 1998. We are clear that, regardless of the outcome of those discussions. we will continue to do all we can to promote and protect the human rights and equality rights of the people who use Welsh public services.

Michelle Morris
Public Services
Ombudsman for Wales

November 2022

Background

About us

We serve the people of Wales in 3 different ways.

Our first role is to handle complaints about maladministration, service failure, or failure to provide a service by most public service providers in Wales, such as:

More information on our process for handling complaints about public bodies in Wales can be found **on our website** (also in **Easy Read**).

Our second role is to consider complaints that elected members of local authorities have breached their Code of Conduct, which set out the recognised principles of behaviour that members should follnemberi7aC393iife050 role is to2erside cont oe ciesncompla

Equality and human rights frameworks

We are committed to the statutory principles and duties under the equality and human rights UK legislation and international frameworks. In looking at our complaints, we consider:

- the equality duties under the Equality Act 2010
- the Articles of the European Convention on Human Rights (ECHR)

Providing reasonable adjustments means that organisations must take positive steps to remove the barriers people face because of

Glossary

When we consider a complaint and find that something has gone wrong with public services, we can intervene at assessment stage or at investigation stage.

When we intervene at assessment stage, we call that an **Early Resolution**. This means we can make recommendations to public service providers faster, without conducting a full investigation.

Sometimes, we decide to issue a **'public interest' report**. We do this for example when:

- there are wider lessons from our investigation for other bodies
-
-
  who complained to us, or
- we had pointed out the problem to the body in the past, but the body did not address it.

'non-public interest' report.

The cases

In this section, we present some of the relevant cases that we closed during 2021/22. For this casebook,

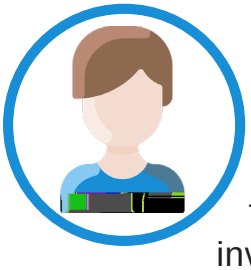
case summaries to make them more accessible and better explain the equality or human rights implications of the complaint. However, formal summaries of these cases can be found on our website **here**.

What we found

We did not uphold some aspects of Mrs A's complaint. For example, we did not see evidence that the clinical decisions taken during Mr A's care were inappropriate. We were also clear that a DNACPR decision is a clinical one, and the views of Mr A and his family would not determine how it was enacted.

However, we were concerned about how the medical staff communicated with Mr and Mrs A and how they documented their decisions. Because of the poor communication and record of the decisions when enacting the DNACPR procedure, Mr A's death was more distressing for his family.

In addition, because of poor communication, Mrs A was not aware of the extent of Mr A's decline and had not expected that her visit was the last time she would likely see her husband. The Health Board did not communicate clearly what would happen to Mr A's belongings, which further contributed to Mrs A's distress.



Because of contrary evidence and poor record keeping around the DNACPR decision, we could not be sure that Mr A and his family knew that a DNACPR procedure had been enacted or were involved in the decision-making process.

If the communication and record keeping were better, the family would have had much needed assurance that the clinicians considered Mr A's wishes. In our view, the situation engaged **Article 8** of the Human Rights Act, which requires the Health Board to ensure that patients can express their wishes about what care and treatment they want to receive.

What we recommended

In addition to an apology and financial redress to Mrs A, the Health Board agreed to share our report with the relevant staff, to make sure that the communication and record keeping failings that we identified would not be repeated.

202004779

Betsi Cadwaladr University Health Board

and a GP Surgery managed by the Health Board

Non-public interest report

Mrs B complained about the dosage of pain medication prescribed by the GP Surgery for her late father, Mr C, and about how this medication was managed. Mrs B also complained about the management and care that Mr C received when admitted to hospital with suspected bowel obstruction ("SBO"). In addition, she said that the Health Board did not communicate well enough with her and did not handle her complaint as it should have.

What we found

We did not uphold the parts of Mrs B's complaint relating to the GP Surgery.

However, we found that there were clinical failings that affected Mr C's management and care in hospital. Although a specialised scan showed that Mr C had SBO, the clinician that treated him did not identify the condition. Mr C's condition deteriorated shortly after the scan and he suffered a cardiac arrest. He underwent 2 cycles of cardiopulmonary resuscitation ("CPR"). When the Health Board contacted Mrs B, she said that Mr C would not want to be resuscitated, but disputed saying that he "should be let go" (as noted in the clinical records). Clinical staff stopped CPR after 12 minutes and Mr C died.

We found clinical communication failings as well as failings in the DNACPR process. The Health Board should have asked Mr C about DNACPR procedure when he was admitted. Because it did not do so, it had to contact Mrs B as Mr C was undergoing CPR. We also found that CPR was not performed for the length of time specified in official guidance and that the decision to stop it was not informed by clinical considerations.

Overall, we decided that the clinical failings in Mr C's management and care amounted to an injustice to his family, who must live with the uncertainty that the outcome could have been different.

We also found that the way the Health Board handled Mrs B's complaint was not as effective or robust as it should have been. This meant that Mrs B and the family had to continue to relive the distressing events surrounding Mr C's death to obtain answers.

What our said

Mr C had a right to give his views about whether CPR should be attempted. By failing to ask for his views when he could have expressed them, the Health Board placed an unfair burden on Mrs B.

This, and the manner of Mr C's death continues to haunt the family. The

202101577

Non-public interest report

Health

Mrs D complained about the care and treatment that her late husband (Mr D), received during his admission to hospital. Mrs D said that a DNACPR form was inappropriately placed on her husband's records against her wishes and without her permission.

She also complained that the decision to stop active treatment and move to end-of-life care after 3 days of admission was inappropriate and premature.

She said that Mr D was intentionally given morphine to overdose him and hasten his death. Mrs D also said that the Health Board did not su f ciently consider her views on these decisions.

Finally, Mrs D complained that Mr D was not discharged from hospital to allow him the opportunity to die peacefully in his care home. She said the Health Board's Bereavement Team did not contact her until several months after Mr D's death.

What we found

We found that the Health Board made the decision about DNACPR correctly. We also found that the decision to change to end-of-life care was reasonable, as Mr D's condition had deteriorated even though he had been receiving appropriate treatment.

The medications prescribed, including morphine, were appropriate and the Health Board communicated with Mrs D as it should have.

We also found that it would not have been possible for Mr D to have been discharged back to his care home because of how quickly he had deteriorated and the context of the COVID-19 pandemic. As a result, we did not uphold these complaints.

However, we upheld Mrs D's complaint relating to the Bereavement Team. The Health Board accepted that the bereavement support service set up during the pandemic should have contacted Mrs D far sooner.

What our said

Mrs D said that the Health Board ignored Mr D's right to life (**Article 2)** because it decided to stop active treatment and, in her view, administered an intentional overdose of morphine. However, Article 2 places an obligation on the Health Board to

What our said

The lack of transparency and administrative failings engaged Mr and Mrs A's human rights under **Article 6** and **Article 8**.

The Council had not assessed B's needs and so it could not show that it had regard to the human rights implications of the arrangements it made for him. Moreover, the Council did not recognise B's concerns when they were brought to its attention by B's parents. In this, it denied him any meaningful participation in the complaints process.

202005028 and 202104393

Betsi Cadwaladr University Health Board and Flintshire County Council

Non-public interest report

Mr C complained that the Health Board and the Council did not tell him in a timely manner about a dispute within the Health Board about Continuing Health Care (CHC) funding, which he expected to cover the cost of care home fees of his wife, Mrs C.

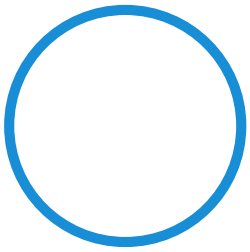
Mr C was also unhappy with the Council's role in his wife's discharge planning from hospital and the funding of her care at the care home.

Finally, Mr C was unhappy about how both bodies handled and responded to his complaint.

What we found

We upheld Mr C's complaints. We found that failings in the processes by the Health Board and the Council contributed to Mrs C having an outstanding social care debt of almost £20,000.

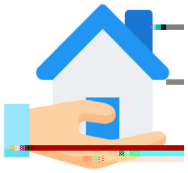
In terms of Mrs C's discharge planning and funding, the Council should have ensured that it informed Mr C of the financial implications of chargeable social care costs. It should also have discussed with Mr C, prior to Mrs C's discharge, the need to complete a financial assessment that would have helped him to reduce the cost.



202004278

Wales & West Housing Association

Non-public interest report



Housing

Mr Y complained that the Association did not appropriately investigate his complaints of Anti-Social Behaviour ("ASB") against his neighbour, another tenant of the Association.

Anti-Social Behaviour ("ASB") means acting in a way that causes or is likely to cause harassment, alarm or distress to one or more persons not of the same household as the perpetrator.

What we found

We found shortcomings in how the Association handled Mr Y's complaints about ASB. The Association communicated poorly and did not keep Mr Y informed about what actions it was taking in response to his complaints. These shortcoming were contrary to the requirements of its ASB Policy.

We also found that the Association had no ASB Procedure explaining how it would deal with occurrences of ASB. That was contrary to legislative requirements and caused an injustice to Mr Y as there was no ASB procedure for o f cers to follow in dealing with his complaint.

We also found, that although Mr Y informed the Association that he had some mental health issues, the Association did not update his records or ask him what his needs were, and whether he required reasonable adjustments. These shortcomings amounted to maladministration which caused Mr Y an injustice.

What our said

Under the **Equality Act 2010**, public sector organisations are required to make reasonable adjustments for disabled people. This can mean changing policies and procedures or providing staf training to ensure that services work for those with protected characteristics.

These duties were relevant in this case because Mr Y informed the Association of his mental health issues and of the impact that the occurrences of ASB had on him.

What we recommended

In addition to an apology and some financial redress, the Association agreed to prepare and publish an ASB procedure. It also agreed that that procedure would include references to the Equality Act 2010 requirements and the duty to provide reasonable adjustments.

In addition, the Association agreed to review its ASB Policy to ensure that it complied with the requirements under the Equality Act 2010. It also agreed arrange training on those requirements and the ASB policy and procedure for its staf.

Public interest reports

202006310

Board") and Swansea Bay University Health Board ("the Second Health Board")

Public interest report

Miss C complained about care and treatment provided to her cousin Ms F, by the First Health Board and the Second Health Board.

Miss C was concerned that the Health Boards missed opportunities to identify and treat the appendicitis that caused Ms F's ruptured appendix.

What we found

We did not uphold the complaint against the Second Health Board, because we decided that it was unlikely that Ms F had appendicitis during the time she was under its care.

However, we decided that the First Health Board failed to suspect appendicitis and admit Ms F to hospital on 2 occasions. It also failed to prescribe antibiotics and arrange appropriate and timely investigations.

After being examined for the first time, Ms F was sent home and told to return for a review and further investigations. When she returned to be examined again, a scan ruled out gallstones as a potential diagnosis. Nevertheless, Ms F was not admitted to hospital to be examined further.

Ms F did not return for further review and she died at home.

On the balance of probabilities, we decided that if the First Health Board had provided appropriate care, it would have identified and treated Ms F's appendicitis, and her death would have been avoided.

What our said

We do not make the finding of avoidable death lightly. Moreover, it is likely that Ms F's final days at home would have been severely blighted by the pain and suffering caused by her undiagnosed appendicitis and infection. The discovery of her body within the family home must have been extremely traumatic for her family.

We decided that the circumstances of this complaint may have engaged the rights of Ms F and her family to respect for their private and family life under **Article 8.**

What we recommended

We recommended that the Health Board apologise fully to Ms F's family for its failings. We also recommended that it assisted the family in receiving financial compensation from the Health Board.

Finally, we recommended that our report was shared with relevant staff for wider learning and that the Health Board reviewed its practices and procedures in the Ambulatory Emergency Surgical Unit and ambulatory settings.

202000661 and 202001667

Betsi Cadwaladr University Health Board

and Denbighshire County Council

Public interest report

Health and Social Care

Mr D complained about his late mother's (Mrs M's) care at 2 hospitals.

Mrs M had bowel surgery (to initially deal with a cancer tumour). She then suffered with persistent nausea, abdominal pain, gastric issues, and consequent weight loss. Mr D said clinicians repeatedly talked about 'anorexia', making Mrs M feel it was her fault and that she needed to try to eat more and yet, when she did, she ended up in worse pain. By the time Mrs M's problems were correctly diagnosed, she was assessed as being too frail (in part from her extreme weight loss) to undergo surgery. Mrs M died the following day.

Mr D also complained that the Council did not offer Mrs M adequate home care support when she was first discharged, which he said impacted on her dignity. Mr D said that the Council assessed Mrs M as being able to climb the stairs to access the toilet – although she was unable to do so. As a result, Mrs M had to use a commode downstairs. Mr D said this caused Mrs M distress. He said the home care service had not been able to meet Mrs M's needs and there had been a 3-day gap in its provision. Due to a break down in this service, Mrs M was readmitted to hospital.

What we found

We found that clinicians did not notice that Mrs M had developed an ischemic bowel (a condition resulting from a reduced blood supply to the intestines). Neither did they identify other clinical signs for her nausea and extreme weight loss.

We could not be certain that Mrs M's death was preventable. However, we decided that because of the failures in Mrs M's care, the Health Board lost an opportunity to consider surgery before Mrs M became too clinically unwell to undergo it.

We also upheld Mr D's complaint about Mrs M's discharge and home care package, including about Mrs M's mobility assessment.

What our said

Collectively (as well as individually), these failings impacted on Mrs M's **human rights in terms of dignity and quality of life**. There was also an impact on the wider **family's rights** in terms of

What we found

We found that the Council did not provide a reliable Assisted Lift Service to the residents, with repeated missed waste collections over a long time. This amounted to serious service failures because some of the Council's most vulnerable residents were denied reliable access to an essential service that should be available to all. The residents, 2 of whom were in their 90s, should not have had to suffer such inconvenience for such a long time.

We also stated our view that, by providing the Assisted Lift service so inconsistently

We also upheld the complaints about the Council's complaint handling. Despite receiving repeated formal complaints and hundreds of calls from the complainants, the Council failed to properly acknowledge or act on their concerns and communicated with them poorly. We found that this caused the complainants avoidable distress over a long time, which amounted to a considerable injustice.

We found systemic problems with the Assisted Lift Service and were very

Early Resolution

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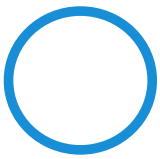
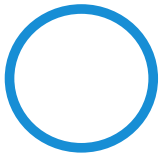
A GP practice

202202881





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