

# **Equality and Human Rights Casebook**

2021/22

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

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## Foreword by Nick Bennett, Public Services Ombudsman for Wales

This will be the third casebook I have produced to focus on cases where I considered that it was right to refer to equality and human rights issues. The previous two casebooks have been well received and I understand that they have been useful in explaining when and how my office considers human rights and equality matters. I consider these issues where they are either at the forefront of a complaint, or where they have been key to the findings I have made.

It is not my role to definitively find that someone's human rights have been breached, or that they have been discriminated against. However, I will comment if I feel that the human rights of a complainant (or a person whom they have complained on behalf of) have been engaged as a result of the actions or inaction of a public body within my jurisdiction. Public bodies in Wales have a duty to consider the human rights of their service users and are under a duty to promote equality and to avoid discrimination. Where I consider it to be appropriate, I will recommend that public bodies undertake specific work to educate themselves about such matters. You will find examples of this within the body of this year's casebook.

As I predicted last year, the COVID-19 pandemic has raised numerous difficult human rights issues which are now being reflected in the complaints brought to my office. At the time of writing, only a small number of these complaints have reached the end of the investigation process, however the human rights issues that they raise are being actively considered by my Investigation Officers and Equality and Human Rights Group. I envisage that next year's casebook will include an array of COVID-19 related issues. Complaints have been received about the impact of the legislation passed in response to the pandemic<sup>1</sup> on personal freedoms, and I am now beginning to see recurrent themes relating to the provision of care and treatment.

Whilst my team continue to use our Standards in Clinical Care to determine whether care and treatment has been appropriate in the circumstances of a complaint, when the timeframe of events complained about post-dates the start of the pandemic, consideration is also being given to any internal or external COVID 19 related guidance. Where the timeframe of the complaint spans a period in which the NHS was under intense pressure, my investigations will also consider the impact of this on the Health Board and Trust's ability to balance the demands on its resources and capacity to provide treatment when reaching a decision. In doing so, consideration will be given to any explanations by those complained about which will be balanced against the COVID-19 related standards or guidance, and the needs of the individual patient.



<sup>1</sup>Coronavirus Act 2020 and its accompanying Regulations

During the height of the pandemic, the public health measures that were put in place to attempt to prevent the spread of infection impacted upon Health Boards' and Trusts' ability to provide treatment for non-COVID-19 related conditions. During times of peak infection, resources were stretched to the point whereby treatments for non-COVID-19 infections were suspended. The increased waiting times being experienced raise both Article 3 and Article 8 considerations for patients. Whilst I accept that an increase in waiting times is inevitable, and I recognise the pressures that all Health Boards and Trusts are under, I do expect there to be systems in place to ensure that patients on waiting lists are reviewed and prioritised in a manner which minimises the harm which stems from these unavoidable delays.

In-patient visiting restrictions which were implemented in March 2020 in an attempt to protect patients and staff alike have proved emotionally difficult for patients and their loved ones. However, it would appear from complaints that I have received that the restrictions have also had practical implications in terms of the level of communication and frequency of clinical updates being provided to family members from clinical staff, which raises Article 8 issues. In a recently concluded investigation, I recommended that a Health Board prepare guidance on the level of communication expected between clinicians and family members during times when visiting is suspend and/or restricted. I hope that this guidance will strike a balance, recognising the demands on clinicians' time but appreciating the importance of ensuring that the families of patients are aware of their diagnosis and prognosis.

Concerns have been raised regarding patients' and family members' involvement in discussions and decisions around DNACPR ('do not attempt cardiopulmonary resuscitation'); again, this may be related to issues with communication between clinicians and family members, but it potentially engages and raises some very serious questions in relation to Article 2, Article 3 and Article 8. The recent report by the Care Quality Commission<sup>2</sup> raised particular concerns about the application of DNACPR decisions to groups of people, rather than decisions being taken based on the assessment of an individual's clinical circumstances. While I have, so far, only had a small number of complaints of this nature made to me, I want to ensure that equality and human rights were properly considered when such difficult decisions were taken.

It is clear that the on-going pandemic and its repercussions, which includes the tricky balancing of people's qualified human rights in pursuit of a legitimate aim, will be with us for some time. I anticipate that this will mean a continued increase in the number of complaints where complainants themselves refer to human rights and also where my investigations identify rights engagement.

Finally, one of the proudest achievements of my tenure is the extension of the Ombudsman's powers to allow own initiative investigations. The Own Initiative report into Homelessness, which was issued in October 2021 is not just timely and relevant, but also raises important human rights and equality issues which I hope to report on further in the next edition of this casebook.

<sup>2</sup>Protect, respect, connect – decisions about living and dying well during COVID-19"  
[https://www.cqc.org.uk/sites/default/files/20210318\\_dnacpr\\_printer-version.pdf](https://www.cqc.org.uk/sites/default/files/20210318_dnacpr_printer-version.pdf)

## Executive Summary

This Casebook includes 13 cases where I found that public bodies failed to consider or safeguard the human rights of service users or to consider their duties to service users under the Equality Act.

Of these cases, 4 resulted in the issue of public interest reports under section 23 of the Public Services Ombudsman (Wales) Act 2019. Section 23 reports are issued when I consider that the themes raised are of wider public interest, for example when what went wrong was significant or ongoing, the issues are systemic, the investigation has identified issues that others can learn from, or have been previously identified by me and lessons have still not been learnt. In addition, a public interest report will be issued when a relevant body has indicated that it does not accept my proposed recommendations.

**7 of the cases led to the issue of non public interest reports under section 27 of the same Act.**

**2 cases concluded by way of settlement rather than proceeding to a full investigation.**

Of the cases included here:

- 9 involved complaints against Health Boards
- 3 of these involved linked complaints against Local Authorities
- 3 involved complaints against Local Authorities alone
- 1 involved a complaint against a GP Practice
- 1 involved a complaint against an Admissions Appeal Panel for a school

The cases cover a range of topics, including:

- Mental health services
- Maternity care
- Social Services and discharge planning
- Social Services and planning for care leavers
- Failure to comply with duties under the Equality Act

I also include one case where a complaint was not upheld, in case this is of interest or assistance to public bodies.

## Background

As Ombudsman, I am committed to the statutory principles of Equality & Human Rights and will comply with the duties imposed on me, and the spirit intended, by the following:

- Equality Act 2010
- The Articles of the European Convention on Human Rights (ECHR) as enshrined in law by the Human Rights Act 1998 (HRA) and
- The FREDA principles (Fairness; Respect; Equality; Dignity; Autonomy) – core values which underpin human rights.

When dealing with complaints, I also give consideration to other statutes that are intrinsically linked to the above, e.g. the Mental Health Act 1983 (as amended) and the Wales Mental Health Measure. In addition, I take account of other relevant Conventions, e.g. the UN Convention on the Rights of the Child 1989 and, in Wales, the Declaration of Rights for Older People 2014.

The HRA incorporates into domestic UK law the rights and freedoms as set out in the ECHR. Some are **absolute** rights, meaning that the citizen should be free to enjoy them, and the state can never interfere with that. There are some **limited** rights, meaning they might be interfered with in certain circumstances (such as times of war or emergency). Finally, others are **qualified** rights, meaning that the state can legally interfere with them in certain situations – e.g. in order to protect the rights of other citizens. The most common rights featured in the complaints considered by my office are the following:

### Article 2

#### **The right to life – an absolute right**

This includes the protection of life by public authorities. Article 2 can be relevant to consider where there is an allegation of avoidable death, provision of life saving treatment or delays in treatment. It places both positive (to do something) or negative (not to do something) obligations on public bodies.

### Article 3

#### **This is the right to be free from torture or cruel, inhuman or degrading treatment or punishment – an absolute right**

Torture has been defined as intentionally inflicting severe pain or suffering on someone. Inhuman treatment causes physical or mental suffering, so could be seen as cruel or barbaric but need not

be intentional. Degrading treatment is extremely humiliating or undignified and, again, need not be intentional. To satisfy Article 3 the treatment would likely need to apply for hours at a stretch and can include neglect of duties, use of restraint, treatment against a person's wishes. Courts have set a high threshold for Article 3, but such considerations can often be viewed through Article 8 (right to respect for private and family life - see below) as the impact on the individual is crucial.

## Article 5

### **This is the right to liberty and security – a limited right**

This can apply when someone is detained in some way – i.e. re not free to leave. Consideration is given to the context and law – e.g. a person may lawfully be deprived of their liberty following a conviction and sentence by the courts. In mental health or care home settings we would consider the procedural safeguards put in place before any detention takes place – such as due process under the Deprivation of Liberty Safeguards. Has the individual been able to challenge that decision – e.g. access to the Mental Health Review Tribunal?

## Article 6

### **The right to a fair hearing – an absolute right**

The right to a fair trial relates to decisions about civil rights or in dealing with a criminal charge. Public bodies should meet this requirement too in their complaints handling processes in terms of procedural fairness. Has the public authority provided a reasoned decision, so someone knows the basis for it in order to decide whether to challenge it further (by any appeals process)? Does the composition of a decision body/panel ensure fairness and impartiality? A right to a public trial can be restricted if exclusion of the public is necessary to protect certain interests and/or if there is a right to progress to a court of tribunal that complies with that requirement.

## Article 8

### **The right to respect for private and family life, home and correspondence – a qualified right**

This article is heavily linked to the FREDA principles of dignity, respect and autonomy. It can include sexual orientation/gender issues, the right to access information held about a person or the right to independent living and to make choices. There is a right to enjoy one's home without it being affected by noise or pollution and to enjoy living as a family, where possible. As noted above it can overlap considerably with the rights set out in Article 3 in matters of dignity.



## Article 9

### The right to freedom of thought, conscience and religion – **absolute (& limited) right**

While the right to **hold** a religious belief is **absolute** there are instances when the right to **manifest** it may be interfered with, so that aspect is a **limited** right – e.g. a pupil wishing to wear a traditional faith form of dress would be manifesting one's religion. However, if the school has a strict uniform code then it could insist that the pupil wear the uniform (thus interfering with the manifestation of their religion). They can still, nonetheless, hold their religious beliefs. There is a right to have children educated in accordance with religious beliefs albeit no duty on authorities to provide separate religious schools on demand. Healthcare bodies should protect an individual's right to manifest religious beliefs where it is practical to meet all the requirements.

## Article 10

### The right to freedom of expression – **a qualified right**

Everyone has a right to hold opinions and express views even if sometimes they are unpopular. Interferences with them may be necessary in the interest of public safety, or to prevent the disclosure of information received in confidence.

## Article 14

### The prohibition of discrimination – **can only be used with other rights**

Heavily linked with the Equality Act, this right is not free standing and so can only be used if linked to one of the other human rights Articles.

## Public Interest reports issued under s23 PSOW Act 2019

### 201900746 (Public Interest – Health - Delay in treatment impacting on dignity)

Mr A complained that his late mother, Mrs B, who suffered with dementia, had been effectively left housebound for the last 8 years of her life due to surgical delays in the treatment and management of her severe rectal prolapse (a rectal prolapse occurs when part of the rectum (back passage) protrudes through the anus).

The Ombudsman's investigation found that consistently from 2011 onwards, the clinical decision-making and rationale shown by the Colorectal Surgeons in terms of Mrs B's rectal prolapse management was not in keeping with accepted clinical practice. As a result, more straightforward surgical rectal prolapse repair options, including less invasive procedures, were discounted in favour of high risk, unconventional and extreme treatment options which if undertaken would have provided Mrs B with little or no clinical benefit.

As a consequence of the failings, Mrs B had to cope with the considerable and ongoing indignity caused by a severe and symptomatic prolapse which included bowel and urinary incontinence. Mrs B's worry about "being caught short" also meant she did not want to risk going to social events or the pensioner social group recommended by the dementia Memory Clinic.

From a human rights perspective the Ombudsman concluded that Mrs B and her family's Article 8 rights had been engaged as the failings had such a significant impact on Mrs B's end years and the time that her family had with her. The Ombudsman said:

**"In particular, opportunities [for Mrs B] to develop and maintain her personal identity through external social interactions/relationships were considerably hampered, at a time when Mrs B was living with dementia. This led, the family believe, to the effects of her dementia accelerating, although I am unable to say whether that was in fact the case. The family's relationship with Mrs B and the quality of the time that they spent together were also affected by her rectal prolapse condition and its wider effect, a situation which was worsened by the uncertainties around her treatment and management."**

The Ombudsman's recommendations included the Health Board reviewing how its colorectal team carried out rectal prolapse procedures as well as the points of clinical learning from the case being shared at an appropriate colorectal clinical forum.

## **201906202 (Public Interest – Social Services – Pathway planning)**

Ms F complained on behalf of herself and a young person, Ms G, who supported the complaint, that a Council had not properly managed the arrangement under which Ms G was living with Ms F. In particular, they complained that Ms F had not been confirmed as a Foster Carer for Ms G, and nothing had been put in place to assist Ms G to continue living with Ms F after her 18th birthday under a “When I am Ready” (WIR) Scheme (a scheme which supports young people leaving local authority foster care).

### **Legal Framework**

The Children Act 1989 defines “looked after” young people as those who are cared for, or accommodated by, a local authority for more than 24 hours. Local authorities can “look after” young people under a voluntary arrangement with their parents, or by way of a Care Order, which gives the local authority parental responsibility for the young person.

The Social Services and Wellbeing (Wales) Act 2014 places a duty on local authorities to prepare “Pathway Plans” for young people, setting out advice and support to be provided to those young people to assist them with their journey to independent living (among other things). It also sets out that for some young people, local authorities have a duty to assist them by making “post 18 living arrangements”. The Code of Practice issued under this legislation also requires local authorities to ensure that each care leaver is provided with “appropriate leaving care support”.

Welsh Government set up the WIR Scheme to prepare local authorities for their “post-18 living arrangement” duties. Its WIR “Good Practice Guide” states that a WIR arrangement may be made where the young person was looked after immediately before their 18th birthday and was living with foster carers in a placement arranged by the local authority, the carers were approved as foster carers for the young person immediately before their 18th birthday, and the arrangement is in the Pathway Plan and is consistent with the young person’s well-being.

### **The Complaint**

Ms G was looked after by the Council from September 2012. The Council was granted a Care Order for Ms G in November 2014. Ms F was Ms G’s father’s partner until 2016, and Ms G lived with Ms F and her father until January 2014. Ms F and Ms G did not have much contact after Ms F and Ms G’s father separated. Following a period living with her mother, Ms G was placed in emergency foster care in April 2018. Ms F and Ms G had contact through telephone calls, and from April 2018, they had face to face contact.

The Council agreed to overnight contact taking place between Ms F and Ms G, and recorded that Ms G would like to live with Ms F once she turned 18 in September 2018. A report was prepared in

August 2018 stating that Ms G should live with Ms F and that Ms F should be temporarily approved as a foster carer and should receive payments equivalent to Child Benefit. Ms G moved in with Ms F a few weeks later. 10 days later, a further note was later made stating that Ms F would not be assessed as a foster carer because it would take too long, and Ms G would be 18 before Ms F was approved. Ms F was also told that the local authority had not placed Ms G in her care.

From September onwards, Ms F raised concerns about her financial situation. She requested a WIR arrangement for herself and Ms G. Throughout late 2018 and 2019, Ms G was advised that she would not receive Housing Benefit or any support with housing costs. Ms G left Ms F's home in June 2020.

In September 2018, Ms F complained to the Ombudsman, who settled her original complaint by the local authority agreeing to approve Ms F as a temporary foster carer and pay her a backdated fostering allowance payment, and review Ms G's circumstances. Ms F later complained that the local authority had failed to consider the WIR scheme for Ms G.

The Ombudsman found that the Council did not properly manage the arrangement by which Ms G was living with Ms F, by clarifying her status as a foster carer or putting anything in place to maintain the arrangement, such as a WIR arrangement. He noted that there was considerable confusion over whether and when Ms F was approved as a foster carer for Ms G, which led to confusion over what benefits Ms G was entitled to, and meant that her transition from being looked after to independence was unduly complicated. The Ombudsman found that there was no appropriate Pathway Plan in place for Ms G, and it was not appropriately scrutinised. He found that the financial strain placed on Ms G and Ms F meant it was unsurprising that the placement ultimately broke down.

The Ombudsman found that these serious failings had engaged Ms F and Ms G's rights to private and family life under Article 8. He also found that the local authority's failure to plan effectively for Ms G's transition from care meant that she was denied an appropriate transitional living arrangement that could have improved her life chances, which was a significant injustice to Ms G. He said that the loss to Ms G went well beyond financial loss, and the long-term impact on her was considerable. He recommended considerable financial redress to be shared between Ms F and Ms G, and other recommendations including that training be offered to staff working with young people on human rights considerations and their implications for practice when working with young people leaving care.

### **20200661 (Public Interest – Health – Misdiagnosis of physical condition as mental health condition)**

Mr D complained about the care and treatment that his late mother, Mrs M received. He complained that clinicians failed to adequately investigate and treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset and weight loss which she developed following bowel surgery, and that the Health Board and local Council failed to accurately assess her frail condition, discharging her home without appropriate support in place. Mr D made a number of other complaints about the care that Mrs M received, and about complaint handling.

The Ombudsman found that physicians had failed to identify that Mrs M had developed a post-operative blockage in her small bowel, and that despite conspicuous radiology and clinical evidence pointing to the presence of a blockage, the physicians had inappropriately attributed Mrs M's pain, aversion to eating and weight loss to a "food phobia". The Ombudsman said he considered that Mrs M's aversion to eating was not of psychological origin but was a response to the pain that she suffered after eating. As such, while Mrs M's general anxiety was addressed by psychiatric input, the idea that her pain was linked to a food phobia (an "irrational" fear of food) was incorrect. This had a profound impact on Mrs M, who suffered avoidable physical and psychological suffering. The Ombudsman found that the failings impacted upon Mrs M's human rights in terms of her dignity and quality of life. There was also an impact on her family's human rights in terms of their witnessing her debilitating decline.

The Ombudsman also found that Mrs M was discharged from hospital without sufficient attention being paid to planning, care-management and recording, which led to her receiving significant failings in home care support. In particular, it was noted that Mrs M could not access her first-floor bathroom, which created an acute problem around her toileting needs, compromising her dignity and placing an improper burden on her family and friends. The Ombudsman said that again, this had impacted on Mrs M and her family's human rights.

The Ombudsman recommended that the Health Board and the Council (who were responsible for the social services provision) should apologise, make a redress payment, and share the report with their Equalities Officers to facilitate training on the principles of human rights in the delivery of care.

### **201905294 (Public Interest – Health – Failure to advise of terminal prognosis)**

Mrs W complained about the care provided to her husband, Mr W, following his oesophageal cancer surgery, which Ms W said that he never really recovered from. Mrs W said that Mr W struggled to eat and became emaciated, immobile, incontinent and depressed. In addition, Mrs W complained that palliative support was only provided 2 weeks before he died.

The Ombudsman found that Mr W should have been given psychosocial support and specialist dietetic support before, during and after his surgery. There was no evidence that the Health

Board provided adequate and appropriate post-discharge care and support to Mr W and it had failed to deal with Mrs W's requests for contact and support promptly. The Ombudsman also found that Mr and Mrs W were not advised on symptoms of recurrence or informed of Mr W's prognosis after investigations had indicated that Mr W's cancer had not been fully removed. There was no evidence that Mr and Mrs W were told of the high likelihood that Mr W's cancer would recur and that, if it did, it would probably have spread. Therefore, the Ombudsman concluded that the Health Board failed to keep Mrs and Mr W fully informed about Mr W's condition, his prognosis and what to expect. The evidence in this case and in previous cases considered by the Ombudsman suggested that this failure was the result of a systemic issue relating to full and appropriate communication with patients, across the Health Board area.

The Ombudsman also found that, whilst Mr W's terminal diagnosis was not apparent until his symptoms recurred, palliative care should have been offered once the outcome of the surgery, and Mr W's poor prognosis, was known. The failure to do so meant that Mr and Mrs W were unable to access appropriate support and review promptly when Mr W's symptoms did recur. As a result, the Ombudsman found that the Health Board failed to provide suitable end-of-life care to Mr W.

In considering whether Mr and / or Mrs W's human rights had been engaged, the Ombudsman said:

**“Given Mrs W's evidence in describing her husband's deterioration, and the effects of that experience without adequate or appropriate advice and support, I think that both Mr and Mrs W's human rights are likely to have been compromised in this case. They should have had the information and support to enable them to receive appropriate care when Mr W had symptoms of recurrence. They should also have had the time to come to terms with Mr W's prognosis and to prepare for his eventual outcome both mentally and with suitable palliative care aids and support. The fact that they did not impacted on Mr W's rights as an individual, and on both his and Mrs W's rights as part of wider family life. This is particularly important at the end of someone's life and the failures identified therefore represent serious injustices to both Mr and Mrs W.”**

After the events leading to this complaint, changes took place to NHS provision in that the area where these events occurred was transferred to another Health Board. However both Health Boards agreed to undertake a number of recommendations which included implementing compulsory training for all doctors and nurses treating and managing patients with gastro-intestinal cancer, covering advanced communication skills and the need for patient involvement in care, including exploring patients' expectations and values around their personal diagnosis and prognosis, as well as the human rights issues identified.

## Non-Public Interest reports issued under s27 PSOW Act 2019

### 202001962 (Health – Assessment and referrals to the Gender Identity Clinic)

#### The complaint

Mr B complained that, from 2017, the Health Board failed to conduct appropriate assessments and make suitable referrals following his request to be referred to the Gender Identity Clinic (“GIC”). He also complained about the standard of communication about progress on his request and said that the Health Board failed to maintain appropriate records.

The Ombudsman found that there were failures to conduct an appropriate assessment in 2017, that an assessment in 2018 failed to identify that Mr B met the criteria for a referral, and that a challenge to the 2018 assessment outcome was not dealt with appropriately. He also found that Mr B had been misled to believe that a referral had been made when it had not and was not kept fully informed about the process of referral or the decisions the Health Board was making.

The Ombudsman found that the clinical records did not reflect the appropriate diagnostic terminology, which might have contributed to the confusion around Mr B’s eligibility for a referral and to his perception that his gender health, and his identity, were not being taken seriously or addressed appropriately.

Individuals are entitled to determine their own gender identity, and this should be respected, the Ombudsman also found that clinicians failed to refer to Mr B using his preferred name and pronouns and so he was not given this courtesy.

The service failures identified had a profound impact on Mr B in terms of his personal dignity, his self-determination and his private and family life. The Ombudsman found that Mr B was probably protected by the Equality Act (gender reassignment is a protected characteristic and transgender individuals are protected from the time that they propose to reassign their gender from the one assigned to them at birth, and do not have to have begun (or completed) any specific treatment, surgery or related process) and that his rights under Article 8 were engaged and impacted upon by the shortcomings identified. By not conducting appropriate assessments and progressing an appropriate referral to the GIC, the Health Board failed to provide Mr B with the opportunity to access appropriate and valuable information, support and gender health care to explore his gender identity and progress his transition. The failure to maintain adequate communication with Mr B prevented him from being fully informed of the clinical decisions being made about him, and his request for a re-assessment or second opinion was rejected without explanation. Finally, by failing to use appropriate terminology to refer to Mr B, the Health Board failed to show respect for Mr B’s identity and protect his dignity.

The Health Board agreed to apologise to Mr B and offer him financial redress in recognition of the distress caused to him as a result of these failings. As the referral process had changed since the time of the events, it also agreed to remind relevant staff of the current appropriate referral process for individuals who require gender health care. The Health Board also agreed to provide training to relevant staff within 6 months, on the current NHS approach to diagnosis and symptoms relating to gender healthcare, trans-inclusive diversity awareness and meeting the needs of transgender individuals.

### **201905949 (Health – Nursing care)**

Mrs A complained about the District Nursing care provided by the Health Board to her late father, Mr B, who had Motor Neurone Disease. Mrs A complained that there had been a delay in providing appropriate continence products and training to her family, a failure to administer palliative care medication, a failure to check Mr B's bed sores, a delay in inserting a catheter, and poor record keeping. Mrs A also complained about an incident in which she said a District Nurse had shouted at her family.

Mrs A said that she and her daughter suffered significant mental health issues as a result of seeing Mr B's suffering over a long period of time and it was a constant battle to ensure care was provided to him.

The Ombudsman found that there had been a delay in the Health Board providing continence products to Mr B and that this delay impacted Mr B's dignity and human rights (Article 8), and Mrs A's human rights as his carer (Article 8). The investigation found there had been no evidence to suggest that the Health Board had considered providing Mr B's family with an oral form of palliative medication which they could administer, and a lack of follow up for issues relating to palliative medication. The Ombudsman found that there had been a failure to assess risks to Mr B's skin on a weekly basis (which it should have done as a minimum), and that there was little engagement with Mr B and his family following an initial assessment regarding his urinary incontinence which led to a missed opportunity to engage the Health Board's Bladder & Bowel Team sooner. The Ombudsman also found several instances of poor record keeping. All these elements of the complaint were therefore upheld.

The Ombudsman found there was insufficient evidence to suggest that the District Nurse shouted at Mr B's family. This element of the complaint was not upheld, but the Ombudsman suggested that the Health Board offer training on dealing with confrontation to its District Nursing Team.

The Health Board agreed to apologise to Mrs A for the failings identified. It agreed to share the Ombudsman's report with relevant teams to facilitate learning, develop an information pack



for families about continence products, and to develop an action plan to address the failings identified by the Ombudsman, to include the relevance of the Human Rights Act to the work carried out by the relevant teams. The Health Board also agreed to audit District Nursing records to ensure that they were being completed in line with its own policies and relevant national guidance.

### **201901286 (Health – Discharge and home circumstances including caring obligations)**

Mrs T complained that her late mother-in-law, Mrs G, had been prematurely and unsafely discharged from hospital following a hip replacement operation. Central to her complaint was that clinicians failed to take into account that Mrs G cared for her grandson (who suffered from Cystic Fibrosis) and that her home was undergoing refurbishment at the time. Consequently, Mrs G could not easily access a downstairs toilet and was unable to empty the commode provided without help. It was said that this compromised her dignity and that no action was taken by District Nurses following a report that Mrs G suffered an episode of diarrhoea post discharge from hospital. Within 4 days of her discharge from hospital, Mrs G had developed pneumonia and passed away, being discovered at home when Mrs T visited.

The Ombudsman did not consider that Mrs G was, clinically, inappropriately discharged. That said, he considered it was wrong for the discharge to take place without steps being taken to contact and assess her grandson's willingness and ability to provide her with any support on her discharge (or any consideration of his own support needs). Furthermore, the Ombudsman felt that insufficient consideration was given to her discharge exposing Mrs G to the risk of a compromise of her dignity; the house refurbishment being incomplete and her difficulty with emptying the commode. This would have been an additional source of anxiety for Mrs G. It also placed pressure on Mrs T in having to try to manage the physical consequences in order to help preserve Mrs G's dignity – especially following Mrs G developing diarrhoea. This impacted on the family life of both (Article 8).

### **201905983 (Health – Care following a miscarriage)**

Ms A complained about the care and treatment she received from the Health Board in August to September 2019 following a miscarriage. Ms A complained about the lack of opportunity to discuss her circumstances with a senior doctor, and lack of advice provided to her following the surgical management of the miscarriage ("SMM"). Ms A believed that an error occurred during the SMM, which led to excessive bleeding and that the SMM failed to remove all tissue. She said that there was a delay in dealing with her excessive bleeding and a lack of communication with her about it. Ms A questioned if she had lost a second baby, which might have been missed on her 12-week scan. Ms A said she was left in the Emergency Department on 12 September, covered in blood.

Ms A said the treatment she received left her traumatised and depressed. She said that following the SMM, the Gynaecology Team rushed out of the room with no explanation, leaving her in a violated state. Ms A felt that something had gone wrong during the SMM.

The Ombudsman found that overall, the level of communication and information provided to Ms A had been appropriate, but that there had been a missed opportunity for her to discuss her concerns with a senior doctor. He upheld those elements of Ms A's complaint on that limited basis. The Ombudsman found no evidence that an error occurred during the SMM or that a second baby had been missed on any of the scans performed by the Health Board. The Ombudsman found that bleeding and retained tissue following SMM are recognised risks and are not indicative of service failings, and that there was no delay or lack of communication in dealing with Ms A's bleeding. These elements of the complaint were not upheld.

The Ombudsman found that there had been a delay in the Health Board assisting Ms A to wash following a gynaecological procedure performed in the Emergency Department on 12 September and that this delay impacted on Ms A's dignity and human rights (specifically Article 8). This element of the complaint was upheld.

The Health Board agreed to apologise to Ms A for the failings identified and to acknowledge the impact of the delay in assisting her to wash on 12 September. It also agreed to share the Ombudsman's report with relevant clinicians to facilitate learning, to remind staff of the relevance of the Human Rights Act to their work, and to remind staff to provide cleaning facilities to patients and to remove surgical equipment if gynaecology procedures are undertaken in the Emergency Department.

### **201903590 (Health - Balancing exercise between rights and the right to dignity post death)**

Mrs M complained that failings in the care and treatment provided to her late son, Mr B, contributed to his tragic suicide in February 2018. In particular, Mrs M complained that mental health clinicians failed to follow up or further engage with Mr B after his discharge from hospital, and that following Mr B's suicide, the family viewed Mr B's body and were shocked to discover that no attempt had been made to conceal the ligature marks around Mr B's neck, or the bruising sustained in attempts made to resuscitate him.

Mr B had suffered periodically with mood swings and was under the care of the Community Mental Health Team for 3 months in 2016 and again from October 2017. He was admitted to hospital voluntarily in November 2017 but asked to be discharged the same day, and it was agreed he should be discharged and contacted within 7 days. Unfortunately, staff were not able to contact Mr B within 7 days. A week later, Mrs M contacted the ward to ask for support, but it appeared that no further contact took place.

Mr B attempted suicide by hanging in February 2018. Attempts were made to resuscitate him at the scene but were not successful. Mrs M attended and was taken to see her son's body, but she said no effort had been made to conceal the ligature marks around Mr B's neck, or bruising from the attempts to resuscitate him. Mrs M said the image would remain with her for the rest of her life.

The Ombudsman found that although Mr B could have been detained on the grounds that he exhibited evidence of a mental disorder with potentially, associated risk, it was appropriate for the clinicians treating Mr B to treat him with the least interventionist approach. This was consistent with Mr B's Article 5 right to liberty and security of person. The Ombudsman noted that in this complaint, there was a difficult balancing exercise between Mr B's Article 2 right to life and his Article 5 right to liberty. However, at the time Mr B was voluntarily admitted to hospital, he had not expressed any clear intention to attempt suicide and was co-operating with treatment, therefore the Ombudsman found that it was reasonable for Mr B not to be detained under the Mental Health Act.

The Health Board accepted that there was a failure by clinicians to appropriately prepare Mr B's body for viewing by his mother, or to prepare Mrs M to view Mr B's body after his death. The Ombudsman said that insufficient thought was given to protecting Mr B's dignity, or protecting Mrs M from additional distress, at a time when her family life had already been grievously disrupted. The Ombudsman commented that this raised the question of whether due regard was paid to the family's rights under Article 8 (right to private and family life) and under Article 3 (which refers to patients' dignity). He said that while he could not determine that the Human Rights Act had been breached the impact of this failing on Mrs M's family life caused her a significant injustice, coming as it did at a time when that right was most in need of protection.

As part of the recommendation made by the Ombudsman, the Health Board agreed to provide training to Emergency Department clinicians on enhancing awareness of the Human Rights Act and its relevance to the work of the Emergency Department team, protecting patient dignity in death, and protecting and promoting the human rights of patients and their families.

## **201905681 – (Maladministration – Recruitment process)**

### **Legal background:**

The Disclosure and Barring Service ("DBS") was established to help employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. There are specific legal requirements around the 3 types of DBS checks that can be sought. The DBS has a published Code of Practice ("the Code") which applies to all organisations that have registered with the DBS to submit DBS checks ("registered bodies").

The Rehabilitation of Offenders Act 1974 (“the ROA”) supports the rehabilitation of ex-offenders into employment. Under the ROA, following a specified period of time, cautions and convictions may become spent. As a result, the ex-offender is regarded as being rehabilitated and treated as if he or she had never committed the offence. A person is not required to declare their spent cautions or convictions when applying for a job and an employer cannot refuse to employ someone based on spent convictions unless an exemption applies.

A Basic DBS check contains details of any convictions and conditional cautions that are unspent. A Standard DBS check contains details of any spent and unspent convictions, cautions, reprimands or warnings. An Enhanced DBS check is suitable for people working with children or adults in certain circumstances and a small number of other roles set out in legislation. An Enhanced DBS check will contain the same detail as a Standard DBS check, if the role is eligible the Child or Adult Barred List can be checked, and this would provide any non-conviction information held by relevant police forces.

The Code requires registered bodies to have a fair and clear policy towards ex-offenders and not to discriminate automatically based on a standard conviction or caution. The Code also states that registered bodies should discuss the content of the disclosure with an applicant before withdrawing any offer of employment. Additionally, it states that registered bodies must use all reasonable endeavours to ensure that requests for DBS checks are in accordance with legislative provisions. Registered bodies must ensure that they are legally entitled to request any DBS certificate being applied for.

## The complaint

Mr X complained about the Council’s conduct during a recruitment process in 2019. Mr X was given a conditional offer of employment subject to a satisfactory DBS check. The Council incorrectly applied for an Enhanced DBS check to include a check of the DBS Child Barred List, as opposed to a Basic DBS check. The Enhanced DBS check disclosed convictions which were spent in 1990. The investigation found that the Council did not use its reasonable endeavours to ensure that the correct and legally permitted DBS check was requested, and if the correct check had been undertaken Mr X’s spent convictions would not have been disclosed.

At this juncture the Council considered (wrongly) that the correct DBS check had been sought and so should then have proceeded to follow the Code and its own internal policies and risk assess Mr X’s suitability for the position in light of the spent convictions. However, the Council did not undertake a documented risk assessment or speak to Mr X directly about the spent convictions. The Ombudsman found that there was a lack of transparency and accountability in the Council’s decision making. The Ombudsman could not be satisfied that the Council weighed Mr X’s rights and interests against those of its clients, employees and the public. This balancing exercise was

required in accordance with Article 8 as decisions were being made contrary to Mr X's right to respect and privacy. Mr X's conditional offer was revoked solely on the basis of the convictions which had been unlawfully disclosed.

The investigation found that Mr X was treated in a manner that was contrary to the spirit of the ROA which was designed to ensure ex-offenders were given the opportunity to move on from the stigma associated with their previous criminal offending and to ensure that discrimination did not occur. The actions of the Council in applying for a disproportionate amount of information and failing to follow its internal policies led to Mr X being denied the opportunity of taking up employment with the Council and left him feeling humiliated and embarrassed. This raised issues of illegality, fairness and the right to privacy. The Ombudsman found that Mr X's human rights had certainly been engaged. Mr X's complaint was upheld.

### **202001536 (Health – Communication with patient)**

Mr P complained about the care and treatment he received from his GP Practice prior to being diagnosed with blood cancer. Part of his complaint focused on the way the Practice responded to his request to allow him to communicate by email at a time when he was concerned about leaving the house to post letters due to his perceived vulnerability to Covid-19.

By virtue of his cancer diagnosis Mr P was disabled for the purposes of the Equality Act 2010 and the Practice was under a duty to consider whether to make reasonable adjustments to its policy or practice in order to accommodate his needs. The investigation found, among other communication failings, that the Practice had failed to consider its responsibilities under the Equality Act. As a result, Mr P had potentially been denied an opportunity to benefit from communicating with the practice electronically.

In upholding the communications aspect of the complaint, the Ombudsman recommended that the Practice Manager undertake appropriate training on the Practice's obligations under the Equality Act.

## **Settlements as an alternative to investigation**

### **202003819 (Social Services – Face masks)**

Mr A complained that the Council had a requirement that he must wear a face mask during supervised contact with his children. Mr A said that he was exempt from wearing a face mask, due to asthma and anxiety. He said that wearing a mask during supervised contact caused him to struggle during the sessions, and also caused difficulties with his breathing in the days following contact sessions.

The Council advised Mr A to provide medical evidence of his conditions, and, if he continued not to wear a mask, to remain 3 metres away from his children, both indoors and outdoors, during contact sessions. The Council said that this was in line with its policy and refused to accept Mr A's complaint because its decision was a properly made decision in line with that policy.

The Ombudsman was concerned that the Council's policy may not be compliant with the regulations and guidance by Welsh Government which were in force at the time. In particular, it noted that the first version of the Council's policy did not mention exemptions for wearing face masks at all. The second version of the policy required parents to provide evidence of exemption. The Ombudsman was concerned that a blanket approach was being taken by the Council which led to certain service users being treated differently as a result of their health conditions, potentially engaging their human rights and rights under the Equality Act.

The Ombudsman felt that the complaint was capable of early resolution, and so contacted the Council. The Council agreed to review its policy and consider whether it complied with Welsh Government regulations and guidance, and with the Equality Act and the Human Rights Act. It agreed to provide a review of the decision and a written explanation of its decision to Mr A.

## **202001427 (Admissions Appeal Panel – A secondary school in the Torfaen area)**

### **Legal background:**

Every school is required to have an Admissions Policy setting out how it will offer pupil places at the school and, in particular, in which categories of preference and priority pupils will be offered places where there are insufficient places for the number of applicants in any year (oversubscribed). Each school will have set an 'admission number', being the upper number of pupils it can admit for each year group. Where the number of pupil applications exceeds the admission number, admission can be denied if it would "cause prejudice to the overall provision of efficient education, or the use of resources". Otherwise, the principle of parental choice prevails. Where there is oversubscription, a pupil denied a place has a right of appeal against that refusal to an Admissions Appeal Panel. Whilst the Ombudsman does not perform an additional appellate function, those dissatisfied with the Panel's decision are entitled to complain to the Ombudsman who will consider due process matters.

### **The complaint**

Ms S had applied to the School for a place for her son, T, who suffered from medical conditions. He was denied a place on the grounds that the School considered it did not have the capacity to manage T's medical needs. The School was not oversubscribed. The Admissions Appeal Panel agreed with the School's decision and T was denied a place on the grounds that managing his condition would be a prejudice to the running of the School. Ms S complained to the

Ombudsman that the Admissions Appeal Panel (and the School) had failed to properly consider and apply the School's Admissions Policy fairly and appropriately. Further, she felt that T was being discriminated against on the grounds of his illness.

The Ombudsman commenced an investigation and noted immediately that the Code of Guidance issued to Admissions Appeal Panels set out clearly when pupils could be refused a place and that no school could impose other conditions in deciding to refuse places other than those published by their Admissions criteria. In this instance, the School was not oversubscribed, so other conditions could not be imposed. Further, the Code clearly informed schools and Admissions Appeal Panels that they could not discriminate or disadvantage children with disabilities. T's medical condition meant he was likely to qualify as having a disability under the Equality Act 2010. Additionally, schools should not refuse to admit pupils because of a protected characteristic under the Equality Act, which would be unlawful. The Ombudsman felt that the matter was capable of an early resolution whereby a new Admissions Appeal Panel should be convened to hear the appeal again, with an apology offered to Ms S for the failure to apply procedural matters properly the first time. In addition, the Admissions Appeal Panel was asked to review all the applications it had refused during the same period to ensure those decision had been taken properly in line with the Code. The Ombudsman further recommended that the Admissions Appeal Panel Clerk and other members undertake training on the statutory requirements for applying admissions criteria and the Code and also undertake training on equality issues and disability discrimination as they related to educational administration matters. The Admissions Appeal Panel agreed to resolve the matter and accept the Ombudsman's recommendations and so the investigation was discontinued. NB It is not within the Ombudsman's powers to make a formal finding of discrimination.

## Not upheld

### 201904596 – (Health – Implementation of guidance and withdrawal of medication)

#### The complaint

Ms B complained about the care and treatment she received from a Consultant Psychiatrist based within the Community Mental Health Team. Ms B complained that the Consultant Psychiatrist did not implement the pregnancy prevention programme (a set of conditions outlined with a Position Statement issued by The Royal College of Psychiatrists entitled “Withdrawal of, and alternatives to, valproate containing medicine in girls and women of childbearing potential who have a psychiatric illness”) appropriately, resulting in her prescription for Depakote (a medication used to treat psychiatric conditions) being withdrawn, until she was administered with a user independent form of contraception.

Ms B said that she was forced into having a contraceptive implant fitted against her will in order to remain on the medication that she felt was saving her life. Ms B said that this was a dehumanising experience. Ms B said that the Consultant Psychiatrist was aware of her distress but placed no value on her life (as she could have committed suicide as a consequence of the medication withdrawal). Ms B also complained that it was inappropriate for the Consultant Psychiatrist to prescribe her Diazepam (to treat anxiety) in the interim, as she had been addicted to the medication in the past. Ms B said that the events outlined led to her human rights being breached and the actions taken were discriminatory.

The Ombudsman found that the Consultant Psychiatrist did not withdraw Ms B’s prescription, rather, the prescription of Depakote was reduced pending a user independent form of contraception being administered. He found that the pregnancy prevention programme, which is not prescriptive, was appropriately implemented. The Ombudsman found that Ms B had overall autonomy in relation to her contraceptive choice; the clinical options were discussed with her on 3 occasions, she was provided with written information and an annual risk acknowledgment form (which set out the risks of the prescribed medication in pregnancy) had been completed. Accordingly, the Ombudsman did not consider that Ms B’s human rights (specifically Article 8) had been engaged. Additionally, the Ombudsman found that whilst the prescription for Diazepam was not ideal there were few alternatives available. The dose prescribed to Ms B was a modest one and clinical guidance supported its use in the clinical situation. Ms B’s complaint was not upheld.



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