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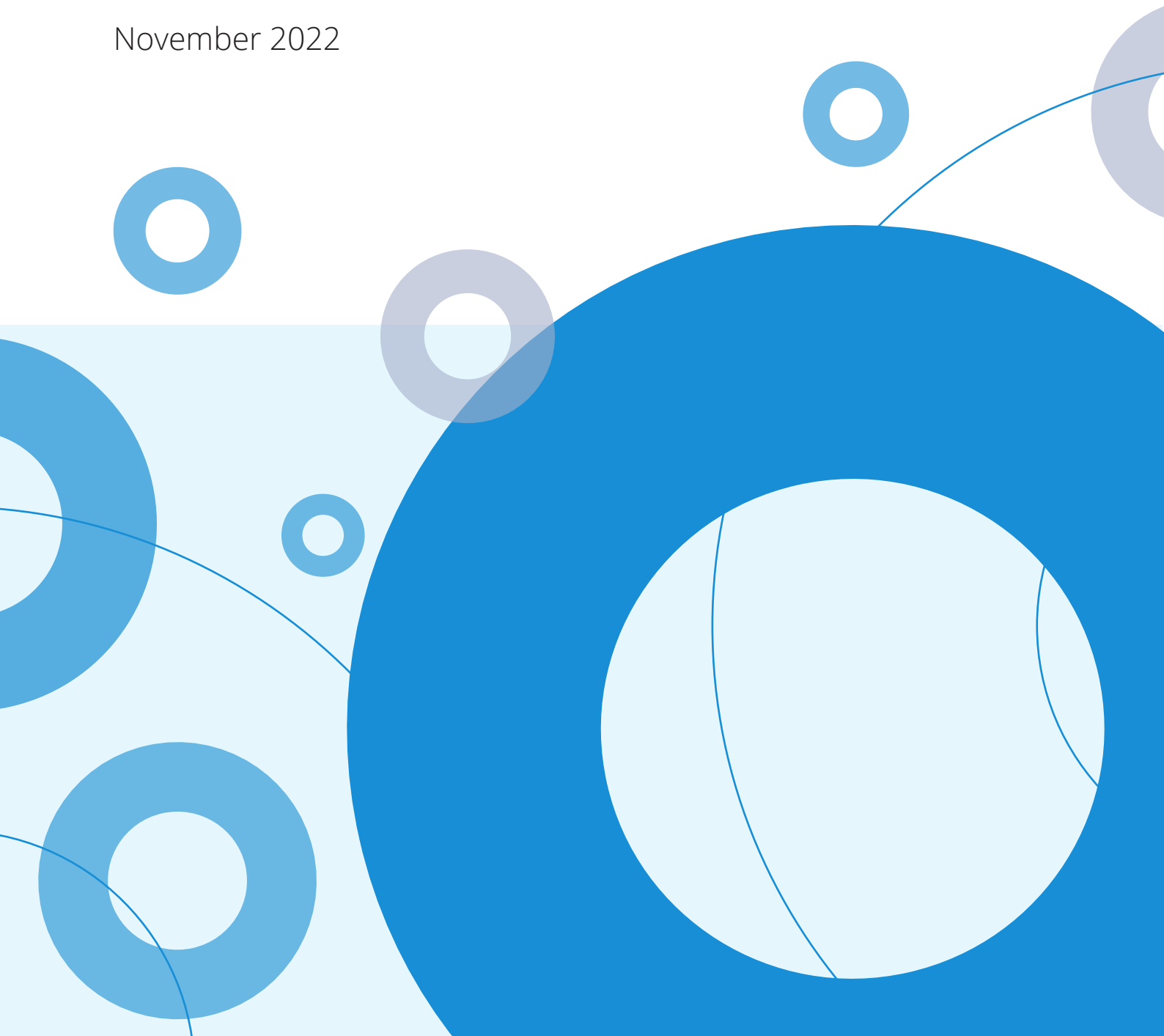
Equality & Human Rights Casebook 2022/23

November 2022



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Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 0300 790 0203
Email: communications@ombudsman.wales

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

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Equality & Human Rights Casebook 2022/23

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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 issues are often inseparable from people being treated unfairly and suffering injustice.

Therefore, if we see that someone's human rights or equality rights may have been engaged in the cases that we consider, we will state that clearly in our conclusions and make appropriate recommendations.

In 2021/22, we considered human rights and equality issues in 59 such cases. We hope that the selection presented in this casebook will help to continue to raise awareness of how we approach human rights and equality issues in our casework.

Many of the complaints that we considered in 2021/22 related to events that unfolded during the COVID-19 pandemic and during the measures and restrictions introduced to protect public health. Several cases in this casebook relate directly to such issues. Continuing the theme introduced in our previous Equality and Human Rights Casebook, we present here 3 cases related to the application of the 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' procedure. We also include one case related to the rules around face-covering exemptions.

In addition, we include several cases in which we decided that the 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:

Local Government

NHS (including GPs and dentists)

Registered Social Landlords

Welsh Goverment and its sponsored bodies

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 follow in public life. In this role, we can consider complaints about:

County and County Borough Councils

Community Councils

Fire Authorities

National Park Authorities

More information on our process for handling complaints about a local authority member's conduct can be found **on our website** (also in **Easy Read**).

Our third role is to drive systemic improvement of public services. Traditionally, we have done this mainly by publicising our findings, for example in public interest and thematic reports, annual letters to bodies in our jurisdiction and casebooks. However, in 2019 we were given new powers to drive systemic improvement. We can now undertake investigations on our own initiative, even when we have not received a complaint. We can also set complaints standards for public bodies in Wales and monitor their performance in complaint handling.

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) as enshrined in law by the Human Rights Act 1998 (HRA)
- the FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy) – core values which underpin human rights.

Equality duties

The Equality Act 2010 introduced a **public sector equality duty** (the 'general duty'), replacing the separate duties on race, disability and gender equality.

Under the general duty we must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Act
- advance equality of opportunity between people who share a relevant protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

The general duty covers the following protected characteristics:

- age
- disability
- sex
- sexual orientation
- gender reassignment
- race (including ethnic or national origin, colour or nationality)
- religion or belief (including lack of belief)
- pregnancy and maternity
- marriage and civil partnership (but only in respect of the requirement to have due regard to the need to eliminate discrimination).

Public bodies in Wales also have **specific duties** to help them in their performance of the general duty.

Under the Equality Act, service providers must provide **reasonable adjustments** to disabled people.

The cases included in this casebook relate predominantly to the protected characteristic of disability and provision of reasonable adjustments.

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

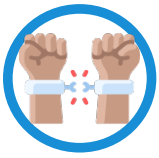
Human rights

The Human Rights Act 1998 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 – for example, to protect the rights of other citizens.

The most common rights featured in the complaints considered by our office are the following:

Article 2 - The right to life



Article 3 - The right to be free from torture or cruel, inhuman or degrading treatment or punishment

Article 5 - The right to liberty and security

Article 6 - The right to a fair hearing

Article 8 - The right to respect for private and family life, home and correspondence

Article 9 - The right to freedom of thought, conscience and religion

Article 10 - The right to freedom of expression

Article 14 - The prohibition of discrimination

The cases included in this casebook engaged predominantly **Articles 2, 8 and 14.** We include more details about the scope of these articles **in the Appendix.**

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.

If we need to conduct a full investigation and we find that something has gone wrong, we usually prepare a report or decision letter which explains our findings. 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
- what went wrong was very significant
- the problem that we found may be affecting many people, not just the person who complained to us, or
- we had pointed out the problem to the body in the past, but the body did not address it.

Otherwise, we usually publish the findings of our investigation as a **'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, we have simplified and adjusted 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**.

Cases about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision means that if your heart or breathing stops, the healthcare team will not try to restart them. The decision should weigh up the potential benefits of resuscitation with the risk of harm to the individual patient. During the COVID-19 pandemic, the Welsh Government and the NHS placed restrictions on hospital visiting by patients' families and on funeral arrangements and social gatherings. They also amended the DNACPR policy and the guidance on the completion of death certificates. Most of these temporary provisions expired in March 2022.

202006132

Betsi Cadwaladr University Health Board

Non-public interest report

Health

Mrs A complained about care and treatment that her late husband, Mr A, received following his admission to hospital in April 2020. Mr A, who was 81 and had several underlying health conditions, was admitted with a sudden difficulty in breathing and shortness of breath.

Mrs A complained that the Health Board did not seek informed consent (from Mr A or her) before it put in place a DNACPR form. She also said that Mr A was not given correct levels of supplemental oxygen to help with his breathing.

In addition, Mrs A complained that the Health Board incorrectly certified that the cause of death included COVID-19 pneumonia, even though Mr A had tested negative. Mrs A argued that because the Health Board stated that her husband had COVID-19, she was not allowed to be with him when he died or view his body in the chapel of rest.

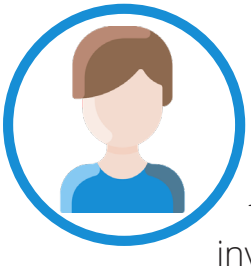
Finally, Mrs A said that undertakers were not able to prepare the body and so Mr A did not have the funeral he deserved. She was later told that his belongings had been disposed of on the day he died because of the infection risk and they were not returned to the family.

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.



What our Investigation Officer said

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

Health

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 Investigation Officer 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 communication failings had also added to the ongoing and significant distress. For those reasons, we decided that the human rights of Mr C and the family (in particular, **Article 8**) had been engaged in this case.

What we recommended

In addition to an apology and financial redress to Mrs B for the complaint handling failings, we recommended that the Health Board engaged with Mrs B, on behalf of the family, to help them access financial compensation.

202101577

Cwm Taf Morgannwg University Health Board

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 sufficiently 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 Investigation Officer 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 provide life-saving treatment except in specific circumstances, such as where treatment is considered futile, or it is in the best interests of the patient not to provide it. The decision to stop active treatment was reasonable and we saw no evidence that morphine was prescribed to hasten Mr D's death.

What we recommended

The Health Board explained that the bereavement support service could not meet its usual timeframe of contacting family members because of staffing issues. It gave us information about the proportion of cases in which it was now meeting the relevant timescales. As the Health Board had already apologised to Mrs D and explained the reasons for the delay, we did not recommend further actions.

Other non-public interest reports

202003442

Cwm Taf Morgannwg University Health Board

Non-public interest report

Health

Mr A complained that the Health Board did not provide appropriate care and treatment to his late father, Mr B, after he suffered a stroke at home and was admitted to the Stroke Unit. Mr B had severe dementia and died in hospital several days after admission.

What we found

We found that, after admitting Mr B, the Health Board did not use the information from his family about his needs. It also did not complete robust tests to check his mental abilities. This would have helped the Health Board's staff to identify Mr B's needs relating to his dementia and make reasonable adjustments for him.

Mr B fell during his stay in hospital, and we found that the Health Board staff had not supervised him as they should have before he suffered that fall. We also found that the Health Board did not complete Mr B's observations as required on the day that he died.

We found that the Health Board's failings affected Mr B's dignity and safety. They also caused Mr A distress due to the uncertainty about whether Mr B's fall could have been avoided or his death prevented.

What our Investigation Officer said

We concluded that the Health Board had not paid due regard to the protection that Mr B, as a person living with dementia, was afforded by the **Equality Act 2010.** This was an injustice to him.

What we recommended

In addition to an apology and financial redress to Mr A for distress and uncertainty, we recommended that the Health Board should review and discuss Mr B's care with relevant clinical staff. We also recommended that it should provide equality related training for the care of patients with a cognitive impairment.

202000712

Cardiff and Vale University Health Board

Non-public interest report

Health

Mr D complained about the care and treatment that his late mother, Mrs C, received from the Health Board during 3 admissions to hospital over 3 months. Mr D said that during Mrs C's third admission the Health Board did not give her appropriate nursing care and did not promptly let her family know about her terminal cancer diagnosis.

What we found

We found that Mrs C's core nursing care plans were not adjusted to meet Mrs C's individual needs for personal hygiene, pressure relief and hydration. Because of that, the Health Board did not fully meet Mrs C's care needs and its nursing interventions were not always appropriate. We decided that this affected Mrs C's comfort and dignity.

We also found that the Health Board's medical staff were wrong to delay the planning of Mrs C's end-of-life care and to not tell her family about Mrs C's diagnosis, until she was in the last few days of her life. If that delay had not happened, it would have been possible for the Health Board to put in place the right support for Mrs C and her family when they needed it.

What our Investigation Officer said

Mr D told us that he felt "robbed" of the time that he would have shared with his mother had he understood her diagnosis and its implications sooner. Mrs C also became too unwell to express her wishes about where she would like to be cared for and to die. Mrs C and her family should have had the time to come to terms with her prognosis and to prepare for her death with end-of-life care support. We decided that this was a significant injustice to Mrs C and her grieving family and that it engaged Mrs C's **human rights** as an individual and her **family's rights** as part of wider family life.

What we recommended

In addition to an apology and financial redress to Mr D and his wider family for the distress it caused, we recommended that the Health Board shared the findings of our investigation with relevant staff for reflective learning.

201907544

Powys County Council

Non-public interest report

Social Services

Mr and Mrs A complained on behalf of their son, B, that the Council failed to safeguard and promote his welfare as a looked after child ("LAC"). They were also unhappy about how the Council handled their complaint.

A looked after child ("LAC") is a child who is in the care of their local authority.

What we found

We found that the Council did not follow the correct administrative process when it managed the funding of B's special educational provision.

We also found that the Council's decision to manage B under the statutory procedures for LAC was based on a wrong interpretation of the definition of "looked after".

The Council had also assumed that it had Mr and Mrs A's consent for B to be looked after without properly explaining their parental rights to them.

Finally, the Council's own investigation report noted how the Council failed to keep Mr and Mrs A informed of arrangements for B, including informing them as a priority when B had been admitted to hospital following a suicide attempt.

This lack of transparency and administrative failings caused an avoidable breakdown in the relationship between Mr and Mrs A and the Council. We also found numerous failings around how the Council handled Mr and Mrs A's complaint.

What our Investigation Officer 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.

By failing to keep Mr and Mrs A appropriately informed of arrangements for B, the Council did not act fairly and in line with a human rights-based approach to the provision of children's social care.

What we recommended

We made several recommendations, including organisational learning, staff training and process reviews, in relation to record keeping, complaint handling and rights-based considerations in social work practice.

202005028 and 202104393

Betsi Cadwaladr University Health Board and Flintshire County Council

Non-public interest report

Health

Continuing Health Care (CHC) is a package of care for adults which is arranged and funded solely by the NHS. Who is eligible for this package is decided through assessment.

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.

What our Investigation Officer said

The ongoing stress impacted considerably on Mr C. The impact was exacerbated by uncertainty regarding Mrs C's living arrangements and past threats of eviction from her care home.

The quality of time that Mr C devoted towards caring for and supporting his wife had been compromised by dealing with the enormity of the accumulated debt.

As a result, we found that Mr and Mrs C's **Article 8** right to respect for private and family life, home and correspondence, had been engaged at a fundamental level.

What we recommended

In addition to an apology and a redress payment to Mr C in recognition of the distress and inconvenience caused to him, our recommendations also addressed the care home fees incurred by Mrs C, with the net effect of there being no outstanding fees for the relevant period.

202003764

Gwynedd Council

Non-public interest report

Housing

Ms A complained about how the Council manged her housing application and about its decision to offer her 2 properties which were unsuitable despite being aware of her partner's (Mr B's) ill health.

Ms A also complained that the Council's new Allocations Policy (a framework where people in most need of housing are prioritised) was discriminatory. That was because of one of the reasons why people could be prioritised - local connection - was based on a parent, sibling or child relationship and not other family unit types. Ms A said, that this meant that her needs were not prioritised as they should have been. Ms A also said that because of poor communication and other failings by the Council's Housing staff, she missed out on being shortlisted for properties.

What we found

We upheld many aspects of Ms A's complaints about the Council's administrative failings. We also found evidence that the communication by the Council was poor. However, we did not uphold Ms A's complaint that the Council's Allocations Policy was discriminatory.

What our Investigation Officer said

It was not unlawful for a council to set local connection as a reason to give priority to an applicant. 'Local connection' is not a protected characteristic under the **Equality Act 2010.**

Ms A and Mr B said that they were discriminated against because of Mr B's mental health and that there was a delay in them being allocated a property. However, we were satisfied from the evidence that Mr B's medical conditions were recognised and these were appropriately reflected in their housing application.

What we recommended

We made several recommendations to the Council about its administrative and communication processes.

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 officers 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 Investigation Officer 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 staff 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 staff.

Public interest reports

202006310

Health

Cwm Taf Morgannwg University Health Board ("the First Health 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 Investigation Officer 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 Investigation Officer 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 their witnessing her debilitating decline.

We are always conscious that we cannot conclude that someone's human rights have been breached. However, the serious events here meant that we had to question whether proper regard was given to Mrs M's human rights in this case.

What we recommended

We made several recommendations. In addition to an apology and financial redress, we recommended that the relevant clinicians reflect on our report and undergo relevant training.

We also recommended that our report was shared with the Health Board and Council's Equalities Officers, to facilitate training to relevant staff involved in Mrs M's care on the principles of human rights in the delivery of care and services.

202005937

Cardiff Council

Public interest report

Waste Collection

Assisted Lift service helps residents who are unable to present waste for collection themselves due to disability, some medical conditions or pregnancy.

Equality Impact Assessment ("EIA") is a way of considering equality duties when planning and providing services.

The Council had committed to providing an Assisted Lift waste collection service to Mrs D, Mrs F and Miss P because these residents were disabled and could not present waste for collection themselves. However, they all complained that Cardiff Council's Assisted Lift Service had failed to meet their needs as vulnerable residents on a consistent basis. They also complained that the Council did not respond adequately to their reports and complaints about problems with the Assisted Lift Service.

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 to its disabled residents, the Council's actions may have engaged the complainants' rights to reasonable adjustments under the Equality Act 2010.

In addition, we found that the Council's EIA did not adequately assess the impact of the Assisted Lift policy. That was because the assessment did not consider relevant operational evidence or engage with disabled or pregnant services users, or their advocates as required by specific equality duties in Wales.

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 concerned that the Council had not addressed those problems and that other vulnerable residents might also be affected.

What our Investigation Officer said

We found that this case may have engaged both human rights and equality duties. The way the Council provided the Assisted Lift Service (and failed to address the problems with it) meant that the residents had to endure accumulating waste, raising health and safety concerns and impacting their enjoyment of their homes. This may have engaged **Article 8**. It was likely that **Article 14** was also engaged, given the impact of the service failures on disabled residents.

Finally, in this case the duty to provide **reasonable adjustments** to disabled people was not enacted as it should have, and the impact on different equality groups among the residents was also not measured as it should have been.

What we recommended

We recommended that the Council should take several actions to put right the injustices experienced by the complainants, quickly improve the Assisted Lift Service for the benefit of all residents who used it, and show that it complied with its duties under the Equality Act.

The Council agreed to urgently update its EIA, to consider how it could minimise the need for complainants to report problems and make it easier for them to complain and speak to a supervisor promptly. It also agreed that the updated EIA should include plans for ongoing review of performance of the Assisted Lift Service, considering feedback from residents' reports and complaints.

Early Resolution

202201561

A GP practice

in the area of Cwm Taf Morgannwg University Health Board

Early Resolution

COVID-19

Mr A is autistic and complained that his GP Practice insisted he wear a face covering (mask) before he would be seen. That was despite Mr A saying that he was exempt from mask wearing because he was autistic. Mr A said that this had caused him anxiety and distress and meant that he did not receive his medication.

When Mr A complained to the GP Practice, it told him that mask exemptions did not apply to GP premises as they were a "high-risk healthcare setting". It said that it would make an allowance for those with "facial deformity unable to wear a mask" (this did not apply to Mr A).

What we found

Mr A's records confirmed that he had received his medication. However, we were concerned that the approach of the GP Practice did not comply with the regulations and guidance issued by the Welsh Government.

It was still mandatory in Wales to wear face coverings in health-care settings at the time of the events complaint about. However, guidance issued to GP practices indicated that mask exemptions could apply in health-care settings – whether for a mental or physical health reason.

What our Investigation Officer said

The GP Practice appeared to be acting contrary to Welsh Government guidance on mask exemptions. It seemed to take a restrictive approach without regard to either the guidance or the **Equality Act 2010.**

Autism is covered by that Act, and so Mr A had a reasonable excuse if he felt unable to wear a mask.

What we recommended

We resolved the case early, without the need for a formal investigation. The GP Practice agreed to apologise to Mr A for not acknowledging that he was exempt and for the distress this caused.

It also agreed to remind all its staff about the Welsh Government's guidance on exemptions - including that autistic people, and others whose conditions are not visible, may still be exempt.

202202881

Rhondda Cynon Taf County Borough Council

Early Resolution

Adult Social Care

Ms C complained that the Council refused to tell her about the health and whereabouts of her late partner, Mr D and did not inform her about his death until several months after he died. She also complained that the Council did not arrange for the administration of his estate, leaving her to attend to matters.

What we found

We found that it was not unreasonable in this case for the Council to withhold information about Mr D from Ms C in the weeks leading up to his death. However, after Mr D died, the Council showed a lack of urgency in establishing that information about his death could be passed to Ms C. This resulted in a 5 month delay in telling Ms C that Mr D had died, which was likely to have caused her avoidable additional distress.

We were also concerned that the Council should have provided appropriate advice and support to Ms C in relation to the settlement of Mr D's estate following his death, in as far as it affected her. Because it did not do that, Ms C was left to resolve matters on her own without support, which cost her avoidable time and trouble.

What our Investigation Officer said

Ms C's desire to receive information about her partner could have engaged her right to a private and family life under **Article 8**. We decided that in this case it was not unreasonable for the Council to withhold information prior to Mr D's death. However, the lack of urgency to find out if Ms C could be told about her partner's death could have engaged Article 8.

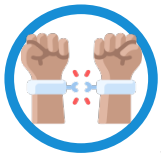
What we recommended

We resolved this complaint early, without resorting to a formal investigation. In addition to an apology and offering financial redress, the Council agreed to contact Ms C to offer her appropriate support and advice with any ongoing concerns relating to Mr D's estate.

Appendix: Some articles of the ECHR

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 - 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) as the impact on the individual is crucial.

Article 5 - 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.

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. 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 - **an 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 Services Ombudsman for Wales

1 Ffordd yr Hen Gae

Pencoed

CF35 5LJ

Tel:	**0300 790 0203**
Fax:	**01656 641199**
Email:	**ask@ombudsman.wales**
Follow us on Twitter:	**@OmbudsmanWales**