Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

Equality & Human Rights Casebook

2020/21

Mae'r ddogfen hon hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Foreword

Last year saw the issue of the inaugural edition of this casebook devoted to cases where I have explicitly felt that it was right to refer to matters relating to equality and human rights. I am happy to note that it was well received as a means of explaining when and how my office considers such issues and my thinking in such cases. As noted previously, I do so where such considerations are either the primary focus of a complaint, or where they add value beyond the traditional FREDA[1] principles which I, and my fellow Ombudsmen, have always promoted.

As explained this time last year, it is not my role to definitively find that someone's human rights have been breached or that there has been actual discrimination, nevertheless, I will comment if I feel that someone's rights may have been compromised by actions or inaction of a public body within my jurisdiction. Where possible and relevant to the complaint, I will also recommend specific learning on human rights and equality issues.

Even though I set out the specific Articles from the Convention and the legal background relevant to the cases in this casebook, I think it's likely that this year, more than any other, the public have become more aware of human rights. With the Covid-19 pandemic we have all seen the rights and freedoms we have traditionally enjoyed restricted. This is of particular relevance to Article 8, and the right to enjoyment of family life which has been curtailed since March 2020 with restrictions on meeting family members we do not routinely live with. It is an example that will resonate with everyone whereby the state using its legislative powers[2] prevented many of us from interaction with our wider family and, sadly, for many even prevented close relatives from being with their loved ones in their final hours. As set out below, Article 8 is a qualified right whereby the state could curtail our enjoyment of this right in the wider public interest. The Coronavirus pandemic, and the need to attempt to restrict its spread to the wider population, is a modern example of the restriction of Article 8 rights that has affected us all.

The pandemic period also saw another action by the state (through the police) against an individual's rights result in global reaction through the Black Lives Matter movement. In publishing our actions under our Equality Plan for 2020/2021, against the backdrop of what happened, we took the step of formulating a "Race and Ethnicity at Work Charter" that includes additional specific commitments to support and promote race equality both at work and in our service provision. More information about the Charter can be found here:

https://www.ombudsman.wales/blog/2020/08/13/race-and-ethnicity-at-work-charter/

[1] Fairness, Respect, Equality, Dignity and Autonomy are the core values underpinning human rights.
[2] Coronavirus Act 2020 and all its accompanying Regulations.

Last year finally saw the PSOW Act 2019 come into force, with its new powers including of Own Initiative investigations in the public interest. The consultation on the proposed topic for the first 'Own Initiative' investigation – homelessness assessments and reviews – was originally launched in March 2020. The consultation paused in the wake of the COVID-19 pandemic and will be re-launched on 23 September. The investigation aims to reflect the current situation in Wales and will now also consider the response to homelessness during the pandemic.

I am proud to reflect on the work undertaken by the office in bringing human rights and equality matters to the fore during my tenure. As we all now enter a phase of what has been termed "the new normal", our collective experiences of late will, I hope, ensure that we do not forget the underlying principles of humanity and dignity which the Convention sets out.

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.

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Cases

Public interest reports issued under s16 PSOW Act 2005

201900014 [Planning - Enforcement]

Flintshire County Council

A landlord ("the Landlord") complained on behalf of his tenant, Mr R, that between 2014 and 2019, the Council failed to take timely and appropriate action to deal with a car wash which had been set up without planning permission. The Landlord highlighted that for 7 days a week, late into the evening, Mr R had to put up with constant noise from the car wash, and could not use his garden without being covered in water/chemicals from the car wash spray. The Landlord noted that as well as being a Statutory Nuisance, Mr R's enjoyment of his home had been adversely affected. Moreover, the situation had left Mr R "extremely stressed" and he now suffered from anxiety and depression.

The Ombudsman's investigation found that despite the Council identifying in 2014 that the car wash was causing a Statutory Nuisance, it took 18 months before a case file was opened by its enforcement section. The Council then took a further 13 months before serving an Abatement Notice. Even though the car wash remained in operation during this period, and the Statutory Nuisance persisted, therefore contravening the Abatement Notice, the Council failed to act. As a result, Mr R had to endure significant, persistent, disruptive and intrusive noise levels and water spray for a number of years.

From a human rights perspective, the Ombudsman concluded:

"I am of the view that the Council did not give due regard to Mr R's right under Article 8… to the quiet and peaceful enjoyment of his home when addressing the concerns raised. This is a significant injustice to Mr R and to the Landlord, in view of the Landlord's obligations [to] Mr R. The fact that the failings continued for over 4 years means that the injustice to Mr R is even more serious."

The Ombudsman made a number of recommendations. These included the Council reviewing its Public Protection Service Enforcement Policy, improving mechanisms for inter-departmental co-operation and collaboration as well as reviewing its internal communication and escalation channels to encourage ownership and accountability whilst discouraging a "blame culture". The Council was also asked to reflect on how the consideration of human rights could be embedded into its practice when deciding whether to take enforcement action, with particular reference to planning control and investigations into Statutory Nuisances

A link to the full copy of the public interest report referred to above can be found here

https://www.ombudsman.wales/reports/cyngor-sir-y-fflint-201900014/

Public interest reports issued under s23 PSOW Act 2019

201902686 [Health –Learning Difficulties and Opthalmology]

Swansea Bay University Health Board

Mrs X complained that her daughter, Y, a vulnerable young adult who has a diagnosis of Atypical Autism, Learning Disability and Mental Health difficulties, received inadequate eye care in light of her known self-injurious behaviour (which included hitting herself on the head and face which were known to cause bruising). Y lived at a specialist residential Unit for people with similar difficulties who could not be managed by community services. Mrs X was concerned that an injury to Y's eye was not diagnosed sooner.

In June 2018 staff noted concerns in relation to Y's right eye which required monitoring, but there was no evidence that monitoring took place, or that these concerns were escalated to clinical staff. When concerns were raised in September about Y's eye, an urgent review was requested. Y was taken to the Emergency Eye Unit in hospital and diagnosed with total retinal detachment and traumatic cataract of the right eye.

The Ombudsman found that Y did not receive an appropriate level of eye care and she was denied the opportunity of a timely referral and clinical review. This caused Y an injustice. It was also a considerable injustice to Mrs X, as there will always be an element of doubt about whether the outcome could have been different for Y, who ultimately lost sight in her right eye. It was not possible to determine this with certainty. He also found a serious communication failing in that Mrs X had not been kept updated. The news of Y's eye condition came as a shock to Mrs X and caused her alarm and distress, which was an injustice to her. The Ombudsman upheld Mrs X's complaint.

The Ombudsman recognises that individuals in institutional care settings are amongst the most vulnerable in society and so are amongst the most vulnerable to having their human rights compromised. He found that the failings in Y's care engaged her Article 8 rights, as the Health Board had not sufficiently demonstrated that it had ensured that the needs of an adult with learning disability, such as Y, were respected. The Ombudsman commented:

"Y's learning difficulties were such that she was completely dependent on those who cared for her... [and so] should have placed a greater onus on staff to satisfy themselves that the symptoms she displayed were investigated further. It is in this context that I am issuing...a public interest report because there are wider lessons for all bodies...who care for vulnerable adults with learning difficulties, to learn from this case. They are amongst the most vulnerable in our society and it is arguable that public bodies should be more vigilant to ensure their needs are met, especially when their vulnerability may make it more difficult for them to articulate or express concerns".

The Ombudsman made several recommendations to the Health Board relating to monitoring a patient's physical condition, communication and staff training. He also recommended that his report was shared with the Learning Disabilities service and referred to the Board, and the Health Board's Equalities and Human Rights team, to identify how consideration of human rights could be further embedded into clinical practice and identify relevant human rights training for Registered Nurses on the Unit (and across the Health Board).

A link to the full copy of the public interest report referred to above can be found here:

https://www.ombudsman.wales/reports/swansea-bay-university-health-board-201902686/

Non-public interest reports issued under s21 PSOW Act 2005 and s27 PSOW Act 2019 (upheld or upheld in part)

201707248 [Health - maternity care]

Aneurin Bevan University Health Board

Ms B complained that staff had not adhered to her birth plan, had failed to respect her wishes and culture - both during her baby's birth and in the provision of after-care. Ms B also said she felt that she had been "badgered" into consenting to a vaginal examination (VE) when she first attended hospital before undergoing an emergency C-section later that day. Ms B was Muslim and was a vegan. She was concerned that a male doctor performed the necessary intimate procedure post-delivery and said that the Health Board had insufficient regard for her "specific wishes and cultural needs for female intervention". Ms B complained that her baby had both been left unattended and fed formula milk (contrary to the birth plan). She said that to this day, two years later, she remained in "heightened distress" about events that day which had caused her "...prolonged traumatic upset and I wake up in tears at the thought that [my baby] was taken from me...whether she was left alone...[and] had been fed formula milk".

Given the matters raised by Ms B, the Ombudsman's investigation considered the Health Board's actions and care with Convention rights in mind. However, he noted that it was not for him to make definitive findings about any infringement of human rights. Some of the language used by Ms B in the complaint bordered on Article 3 (inhuman and degrading treatment), however, in line with the courts' approach, the Ombudsman felt it was more appropriate to consider Ms B's views and feelings through focusing on Article 8 (which encompasses dignity and self-determination). He also noted that Article 9 (right to hold and manifest one's religion) was relevant in this case given Ms B's faith.

During the investigation it was found that there were some missing pages in the baby's clinical records that might have cast doubt on the Health Board's assertion that the baby had not been fed formula milk. In analysing all the records, it was noted that Ms B's clinical records were intact. When read together with the baby's records, it was clear that breastfeeds were documented throughout. Other than once, for a few minutes (to settle the baby while Ms B rested), there was no evidence the baby had been taken from Ms B. These complaints were not upheld. In relation to the VE, it was not possible to say how Ms B had been asked to consent to one, but the Ombudsman noted that a VE (with consent) was a necessary process to establish the progress of labour. The Health Board had respected Ms B's wishes when she declined her consent the first time one was to be performed (by a female doctor). When an emergency C-section became necessary, there were two doctors present in theatre – a female and a male. The female undertook the safe delivery of Ms B's baby, but she was then called away to another birthing emergency on the ward. She carried seniority that night.

The Health Board had already apologised for this, saying there was no option in the circumstances that evening but to leave the male doctor to complete the procedure, which he was competent to perform.

While noting Ms B's Article 8 and 9 rights, the Ombudsman noted that the Health Board had due regard for Ms B's cultural needs and had respected her wishes as far as it could. Ms B had otherwise been cared for by female staff throughout. Given other mothers' needs at a busy time, when Ms B had already been safely delivered of her baby, he felt that the Health Board was entitled to interfere with Ms B's rights. This was to ensure regard for the similar rights of other mothers needing medical care to ensure safe delivery of their babies that night. Article 8 is a qualified right and a public body is entitled to undertake a balancing act. It followed that the Health Board was also entitled to adopt that similar approach in relation to Article 9 as it had done all it could to meet and protect Ms B's religious requirements throughout and in the prevailing circumstances. The Ombudsman did not uphold the complaint as made. However, he did find that communication with Ms B throughout, and in theatre at the time, might have been better. It may have meant a greater understanding of the situation early on (which might have avoided the complaint). He recommended an apology and some financial redress be made for this communication failing.

201701203 [Education SEN]

Denbighshire County Council

Mrs X complained that the Council had failed for a year to consider carrying out an assessment of her child B's educational needs. She also complained that it had failed to complete an assessment within the relevant timescale, following it conceding her appeal to the Special Educational Needs Tribunal. Finally, Mrs X complained that the Council had discriminated against B, who suffered with known mental ill health, by the comments it had made during the assessment process.

The Ombudsman found failings in the case and upheld most of the complaint. In doing so he also noted that the United Nations Convention on the Rights of the Child was relevant in this case (Articles 12 & 13 – freedom of expression and of thought and belief). B was entitled to express an opinion and contribute towards the assessment of needs. The Ombudsman acknowledged that the Council had made a reasonable adjustment (as required by the Equality Act 2010) in visiting B at home to conduct the assessment (not its usual practice) and it had attempted to ascertain B's views.

Whilst it was not for him to make findings of discrimination, the Ombudsman, nevertheless, felt that the Council's comments at issue had failed to sufficiently consider B's known mental ill health and that there was a lack of evidence suggesting that it was B's active choice to fail to engage in the assessment process. This was why Mrs X felt the Council had discriminated against B. The Council was asked to reflect on the Ombudsman's findings and comments.

201803094 [Health - due process and family life at end of life]

Aneurin Bevan University Health Board

Ms Y complained about the care and treatment her partner, Mr Z received in hospital, and that she was treated unfairly. Ms Y complained that the Health Board did not consider Mr Z's human rights when it implemented safeguarding procedures and when it decided that he should not be resuscitated. Ms Y also complained about the way her complaint was handled.

The investigation found that the Health Board failed to make an urgent cancer referral for Mr Z and the findings of a scan were not fully reported to Mr Z and Ms Y. Consequently, they were unable to consider what options were available to them or have meaningful discussions about the situation. Whilst the Health Board had safeguarding concerns about Mr Z (owing to alleged actions of Ms Y), its recording of information about this was inconsistent. The Health Board failed to discuss these issues with Ms Y or act on them, until it became concerned about Ms Y's behaviour towards staff on the Ward. The investigation also found that the Health Board used the safeguarding process to restrict Ms Y's access to the Ward instead of its policy on handling aggression thereby denying Ms Y the opportunity of addressing the concerns and also any right of appeal against the restriction, which that policy would have allowed. In imposing such a restriction in this manner, the Ombudsman said that the Health Board failed to fully consider Mr Z and Ms Y's right to family life (Article 8). It also failed to ensure that Mr Z had a voice in the decision it took. Despite giving Ms Y an assurance that she would be contacted if Mr Z's condition deteriorated, it did not do this. Mr Z died on a day when Ms Y was restricted from visiting the Ward. The Ombudsman found this to be a significant injustice to both Mr Z and Ms Y.

The Ombudsman made several recommendations including a review of relevant policy, with specific reference to balancing the human rights issues and to review the current knowledge of staff who may be involved in balancing human rights matters when making decisions.

201807750 & 201807994 [Health - end of life]

Swansea Bay University Health Board and a GP practice in its area

Mr C, who had other health issues, suffered a delay in diagnosing his liver failure and review of his eligibility for a liver transplant. Mr C, sadly, later died. A Clinical Adviser to the Ombudsman found that it was unlikely Mr C would have received a liver transplant given the severity of his liver disease and because of his other health issues. The Ombudsman found that being uninformed of the terminal nature of Mr C's liver failure meant he and his family were not given any opportunity to prepare for his death or plan his end of life care. Commenting on Mr C and his family's Article 8 rights in this case, the Ombudsman said:

"They should have had the information, and the time, to understand and come to terms with Mr C's diagnosis and to prepare for his eventual outcome. The fact that they were not given this opportunity impacted on Mr C's rights as an individual and on his family's wider needs as part of family life."

The Ombudsman found this to be a serious injustice to Mr C and his family. He asked that the clinicians involved with Mr C reflect on the findings and conclusions reached.

201802486 [Health - elderly patient and falls risk]

Hywel Dda University Health Board

Mr A complained about the care of his 94-year-old mother, Mrs B, following her admission to hospital. Included within his complaints were concerns that inadequate risk assessments had been undertaken relating to her getting out of bed and falling and that there was an unreasonable delay in establishing that she had sustained a fractured pelvis.

Whilst not upholding many of Mr A's clinical related complaints, the Ombudsman upheld the complaint about inadequate risk assessment given it was noted that Mrs B had a tendency to wander on the ward but that she had not been provided with either a walking frame or suitable footwear at the time of her fall. Leads from a cardiac monitor were also discovered tangled around Mrs B's legs. The Ombudsman commented that in relation to older persons, like Mrs B, the Health Board should have focused on prevention, treatment and rehabilitation so that Mrs B could maintain mobility and autonomy for as long as possible, as enshrined within the requirements of Article 8. The fall had a significant impact on Mrs B's autonomy. From the evidence, it could have been prevented with appropriate measures in place. He recommended that nurses on the ward undergo training on falls prevention matters and the issues identified in his report.

201806802 [Social Services and care provision]

Pembrokeshire County Council

Mrs X, who had been diagnosed with a terminal condition, complained that the Council did not assess her needs for care in a timely manner, did not provide her with support to meet her needs in a timely manner and did not give proper consideration to her personal circumstances. Mrs X also complained that the Council did not handle her complaint properly.

The Ombudsman upheld all four aspects of Mrs X's complaint. He found that Mrs X's needs for care were not assessed within the Council's own timescale for standard assessment, even though she was terminally ill, and as a result, Mrs X was not provided with support to meet her needs in a timely manner or, in fact, at all. This caused a significant injustice to Mrs X who was left to manage without support and in a weakened condition.

The investigation found that the Council should have taken into account Mrs X's personal circumstances, particularly her terminal condition, and expedited her assessment. Not doing this was a service failure which caused significant injustice to Mrs X.

The Ombudsman also commented that the case engaged Mrs X's rights under Article 8 of the Convention because she was not able to live her life as independently as possible for as long as possible. The Ombudsman was not satisfied that the Council had properly considered Mrs X's human rights, or fulfilled its duties under the Equality Act, given Mrs X's disability (her terminal condition).

The Ombudsman made a number of recommendations including training of the relevant team, amendment of relevant policies and referral of the case to its Equalities and Human Rights officer.

201806111 [Health - communication and end of life]

Betsi Cadwaladr University Health Board

Mr Y complained about the care afforded to his late partner Ms X who had been diagnosed with mesothelioma (a type of cancer that develops in the lining covering the outer surface of the body's organs; mainly the lungs). Mr Y was concerned about missed opportunities for earlier referrals / treatment and about Ms X's palliative care / end of life experience.

Assisted by advice from his professional advisers ("the Adviser(s)"), the Ombudsman noted that there was no national guidance in place at the time of events on the management of mesothelioma. An Adviser commented that Ms X's diagnosis could have been confirmed some 3 months sooner albeit this did not adversely affect her treatment options given that the chemotherapy that could have been offered would only have extended her life by some 3 months. Ms X's tumour did not respond and although there were no clinical trials she could have been eligible for, the Adviser acknowledged that an earlier diagnosis might have benefited Ms X in terms of her psychological distress about an uncertain diagnosis, and to help her plan. The Adviser also expressed concerns about communication

with Ms X about her condition as certain results were evidently not discussed with her and neither was an early referral for support made to lung cancer specialist nurses (Macmillan Nurses). Whilst overall her clinical care was appropriate, earlier discussion might have enabled Ms X to be admitted to a hospice sooner.

The Ombudsman found that the delayed referral to Macmillan Nurses and the communication failings in turn leading to delayed hospice admission caused both Ms X and Mr Y an injustice. The communication failings meant that Ms X was denied the opportunity to express views about her treatment, as well as both she and Mr Y being denied the ability to properly plan and prepare for the eventual outcome. This Ombudsman added that this would have significantly added to Ms X and Mr Y's distress at an already very difficult time.

201903187 [Health – Equality Act - care of patient with learning disabilities]

Aneurin Bevan University Health Board

Mrs W complained about the nursing care her son, Mr X, received following abdominal surgery and about staff failing to make provision for his disability. Her complaints included a delay in changing Mr X's bedding/clothing when necessary, such that she said her son was "covered in his own vomit for hours". Even after being cleaned Mrs W said that Mr X was still left in a soiled gown as it was said there were no spare gowns on the Ward. She maintained this compromised his dignity.

The investigation found that a "traffic light system" the Health Board had in place for ensuring the needs of a patient with a learning disability were understood and provided for was not implemented in Mr X's case for 10 days after his admission. Thus, there was no personalised care plan for Mr X and consequently no reasonable adjustment made to ensure his learning disability was provided for in accordance with the Equality Act ("the Act"),.and so he was not involved in decisions relating to his care. The Ombudsman found this failing to be an injustice to Mr X as had he understood what was happening, and had he been involved in some decisions relating to his care, it was possible the events would have proved less stressful for him.

In relation to the issue of clothing, the Health Board had apologised for the delay in changing Mr X saying that nursing staff would not knowingly have left Mr X in a soaked, soiled gown. The Ombudsman considered this was, in part, linked to the failure to provide for Mr X's learning disability. There was no record of the attempts the Health Board said there had been to provide 1-1 care for Mr X and no assessment documentation to support such a need. Had he been receiving 1-1- care then delays to changing his bedding/clothing might have been minimised. He concluded by saying:

" In this case Article 8 of the Convention rights, in particular Mr X's right to make personal choices about his life and to be treated with dignity, was engaged, and it seems to me that the Health Board did not have sufficient regard for this."

He made recommendations including that staff undergo refresher training on the traffic light system and the importance of ensuring the needs of patients with a learning disability are recorded and met. Such training should include an understanding of the impact of not following the process, as in this case, on a person with a learning disability and, consequently, on the care provided.

201803704 and 201803703 [Health - Equality Act - failing to provide a reasonable adjustment, removal from the patient list and alleged discrimination]

Two GP practices in the former Abertawe Bro Morgannwg University Health Board area

Ms A had a diagnosis of borderline personality disorder and had suffered from anxiety and depression. She was known to the Community Mental Health Team service. She was removed from another GP Practice's patient list owing, it was said, to the breakdown in the patient /Doctor relationship. This is permissible. Ms A was placed on Surgery A's patient register (case ref 201803704) although she lived outside its area. Patients are usually expected to register with the Practice covering the area in which they reside. Ms A was removed from Surgery A's list and placed on the register with Surgery B (case re 201803703).

Ms A complained that she had requested to remain on Surgery A's list but that it had decided to remove her. This, she said was unreasonable given her disability and that she had made the request as a reasonable adjustment. She described the decision as making her feel anxious and "in a vulnerable place". She also complained that Surgery A had passed on factually incorrect and inappropriate information about her to Surgery B. In relation to Surgery B, Ms A complained that it had required her to sign an "Acceptable Behaviour Contract" (ABC) in relation to accessing services and care on her first visit. Her subsequent contacts with Surgery B (and an out of hours service) were by telephone. Ms A complained that she was not able to see a GP on 3 separate occasions. She said that she had felt "under duress" when asked to sign the ABC and that it was unreasonable to ask her to do so. She also said that GPs not seeing her was discriminating against her because of her mental health issues. Ms A maintained that she had been placed at a disadvantage as a result.

The Ombudsman noted that a GP Surgery is for the purposes of the Equality Act 2010 ("the Act) carrying out a public function by virtue of its contract with the Health Board to deliver care under the NHS. Accordingly, the duties set out, including of making reasonable adjustments for a disabled person, apply. GPs like all public bodies must therefore routinely consider each of the equality aims set out in the Act when making decisions, designing policies and delivering services.

The Ombudsman noted that, in light of Ms A's health and issues raised, such as a reasonable adjustment request, the Act was engaged in her complaint and whilst not for him to determine definitively any breach he would comment on the matters raised. He was satisfied that Surgery A was

permitted by the relevant Regulations (address reasons) to require Ms A be removed from its list and there were no clinical reasons to render that decision inappropriate. Nevertheless, he was critical of the way in which Surgery A had failed to adequately communicate its reasons for doing so clearly to Ms A, such that the failure caused Ms A "avoidable and understandable distress". The Ombudsman was not satisfied either, on the evidence before him, that at the time Ms A made the request for reasonable adjustment, Surgery A had considered it properly, or contemporaneously, in the spirit of the Act. He was concerned that Surgery A implied it would not consider retaining a patient's name on its list by way of reasonable adjustment. In that respect it had failed to demonstrate that it had considered Ms A's request for reasonable adjustment in the manner intended by the Act. The decision had caused Ms A distress as she had explained. Surgery A was asked to introduce a reasonable adjustment policy.

In relation to Surgery B the Ombudsman's Adviser ("the Adviser") said that an ABC was not itself inappropriate as it "only asked the patient to agree to behaviour that would normally be considered as acceptable for any patient." That said, he questioned the use of it in Ms A's case given her removal from Surgery A's list had not been for behaviour reasons, and there was no corroborative evidence to show that she had exhibited behaviour to warrant her being asked to sign it on the day that she was asked to (on her first visit). He expressed concern about the brevity of many of the clinical records made by Surgery B albeit clinically there was nothing to suggest Ms A 's health had been impacted by the consultations (mostly telephone) she did have. In recognising that sometimes it is necessary for ABCs to be signed, and that GPs and their staff should not be subjected to unacceptable behaviour, the Ombudsman noted that it appeared unfair in the circumstances for Surgery B to ask Ms A to sign one when it did. Ms A's concerns about this were sufficient to engage the Act, in the Ombudsman's view, and he expressed concern that Surgery B failed to show that it considered its duties under the Act before asking her to sign the ABC. Surgery B was asked to apologise.

201902717 [Health – private life including mental health]

Hywel Dda University Health Board

Legal Background: The Mental Health Act 1983 ("the Act")

The Act underpins the treatment of a person with a mental disorder against their will. This includes being detained in hospital under its provisions (often referred to as 'sectioning'). Where someone is already a hospital patient s5 permits their detention for up to 72 hours if a relevant doctor certifies it as necessary. Under s2 the individual needs to be suffering from a mental disorder and their detention must be warranted in the interests of their health or safety (or safety of others). Someone with an eating disorder may have a mental health disorder for the purpose of the MHA and, if so, refusing treatment endangering their health can be grounds for not only detention but, in severe cases, compulsory treatment. The Act provides that a designated Approved Mental Health Professional (AMHP) has legal powers to request police aid to convey an individual to hospital if there is a reason to believe (after assessment) that the person is suffering from a mental disorder and in need of hospital treatment.

The complaint

Mrs A complained about matters relating to surgery performed to deal with gastric symptoms. Included in her concerns was a claim that her past eating disorder had influenced decisions about her post-surgical care. Mrs A had suffered from anorexia in her teens but was not known to any eating disorder service at the time of these events (she was then aged 49). She also complained about how a Health Board clinician had acted in despatching the police to her home after she had abruptly self-discharged from hospital following an admission dealing with her ongoing gastric issues post-surgery. Mrs A recounted that she had to go to hide in the attic with one of her children, who was crying and terrified, while her husband spoke with the police to persuade them that she did not need to be taken back to hospital. This event, in particular, she said, had caused her and her two children significant and ongoing distress.

Upholding some of the clinical aspects of Mrs A's complaints, the Ombudsman found no evidence to suggest that the delay in undertaking some action was influenced by attributing Mrs A's ongoing symptoms to her past eating disorder. However, the Ombudsman, following advice from a Psychiatric Adviser, found that the police attendance at Mrs A's home was inappropriate, based on a clinician wrongly interpreting the powers set out in the Act (see above). There had been no involvement or assessment by an AMHP in Mrs A's case, and evidence showed the clinician concerned had confused the law on mental capacity with the decisions for treatment under section provided by the Act. It had not been established if Mrs A's past eating disorder was contributory to her lack of response to nutritional treatment and gastric issues. The Adviser commented that the "police involvement stemmed from the lack of experience and confused understanding of capacity and detention" by the clinician concerned.

The Ombudsman found that this incident also engaged human rights matters. He said:

"Reading the statements supplied in support of the complaint, one cannot help but be struck by what the children especially have written, and the way Mrs A described how she felt at the time... There is no doubt, too, in my view, that Article 8 is engaged here...The police attendance at the request of the Health Board caused a distressing event and disturbance to the entire family's life on [date]. It lacked respect for their private and family life and continued to have an impact beyond that day. This was an injustice to the whole family".

The Ombudsman recommended an apology to Mrs A for the care failings identified and to the family for the distress caused by the police incident. He also recommended an element of financial redress to reflect that distress. Additionally, he recommended that junior doctors in the clinical team treating Mrs A undergo training (including refresher training where relevant) on the distinction between capacity and MHA detention provisions, and that the training should also encompass human rights matters. The Health Board should thereafter consider rolling out that training to other clinical teams.

Settlements as an alternative to investigation

The PSOW Act enables me to consider resolving a complaint as an alternative to an investigation. This has the benefit of allowing formal recommendations to be made to ensure lessons are learnt as well as a swifter outcome for a complainant.

I can only do so where it is a complaint I could have investigated and will do so in cases I consider appropriate.

The settlement example featured below was possible because of the early identification and consideration of human rights and equality matters, which was to prove pivotal in enabling the resolution of the complaint.

201906728 [Adult social services – disability services]

Cardiff Council

Mr A had been receiving support from the Council's Social Services department since 2009, to assist with eligible needs arising from his health conditions. In August 2017, he raised 89 complaints dating back to matters from 2013. These were the subject of an independent investigation (under the statutory Social Services complaints procedure – known as a Stage 2 investigation), which concluded in December 2018. Mr A complained to the Ombudsman about the time taken by the Council to investigate his concerns, and about the Council's failure to provide timely and appropriate remedies.

The Ombudsman declined to investigate the substantive complaint issues in view of the thorough and robust investigation that had already been carried out. However, he considered that the findings raised significant concerns at an administrative level, and more widely in terms of how effectively the Council had met its obligations under the Human Rights Act 1998.

The Stage 2 investigation had found that the Council failed to follow the correct administrative process before reducing Mr A's care package, giving rise to significant uncertainty around whether it met his assessed and eligible support needs from at least 9 March 2016. After January 2017, there were occasions when the Council failed to fulfil its statutory duties towards Mr A, and he was left without care. At these times, he was exposed to potential harm and generally living with very little quality of life. The Ombudsman considered that the Council had also failed to consider the impact of these changes on Mr A's dignity, his ability to live independently, and to exercise choice and control, engaging his human rights under Article 8.

The investigation also found that the Council had behaved in a way that was procedurally unfair to Mr A by not giving him enough information to understand the basis of the changes that were made to his care package, or to challenge them. The Ombudsman considered that this was enough to engage Mr A's human rights under Article 6.

Finally, the Council delayed responding to some of the preliminary findings of the complaints' investigation, meaning that opportunities were lost to put matters right as soon as possible. When the Council did respond, it did not acknowledge or offer sincere apologies for many of the significant failings identified. Further, it did not fully recognise the impact of those failings on Mr A.

The Ombudsman was very critical of what happened in this case and commented that central to applying human rights in practical terms is recognising the service user (Mr A) as an individual and ensuring the delivery of care most appropriate to their needs.

He made a number of recommendations, including an apology and a significant payment of financial redress totalling £9000. This was reflective of the serious administrative failings found, and their significant impact on Mr A, as well as for poor complaint handling.

Not upheld

As Ombudsman, I act impartially. Consequently, having scrutinised the evidence, there are many complaints that I do not uphold, including those where human rights may have been explicitly raised by the complaint.

201803425 [Health - mental health]

Betsi Cadwaladr University Health Board

Legal Background: The Mental Health Act 1983 s2 ("the Act") - see also above

A patient may be admitted and detained in hospital for up to 28 days for assessment in the interests of either their own health or safety or the safety of others (s2 of the Act). This means that the right to liberty afforded by Article 5 can be lawfully impacted upon. The Act also allows a nearest relative to ask for a hearing within 72 hours to request that the patient be discharged, and then to request the review of the detention to be considered by the Mental Health Tribunal for Wales ("the Tribunal"). The Code of Practice to the Act covers the use of seclusion (confining the patient to a room which may be locked), if necessary, but states it to be used as a last resort and for the shortest possible period of time.

The complaint

Mrs J complained about the care and treatment of her daughter, Ms L, when she was an inpatient at a specialist mental health hospital following admission in early July. Following periods of aggression displayed by Ms L towards staff and others post admission, on 15 July staff resolved to use seclusion for the first time after Ms L had been physically aggressive and injured 4 members of staff. A seclusion room was used twice in the morning, although the doors were unlocked while Ms L remained inside. It was used again in the afternoon and in the evening for approximately 2 hours. Mrs J expressed concerns about this and asked if Ms L could be discharged home to her care. Ms L was reviewed and came out of the seclusion room. On 18 July Ms L was given a week's leave (permitted by s17 of the Act) and returned home. A week later she was discharged from the s2 detention. Mrs J complained about various aspects of her daughter's care including saying that Ms L's assessment had not been thorough or unbiased, and that Ms L had not been aggressive as maintained, rather she had an untreated urinary tract infection ("UTI") as well as gastric problems which amplified her behaviour.

Mrs J also complained that, as her daughter's nearest relative, she had been given insufficient information about how to appeal Ms L's section, and that she had repeatedly asked for her to be discharged home. Despite staff saying Ms L had no capacity, Mrs J said they had allowed her daughter to refuse to see her GP or an advocate and Mrs J was appalled at how long her daughter was kept in seclusion.

In advising the Ombudsman, a psychiatric adviser ("the Adviser") said that it was difficult to judge whether seclusion was necessary on any specific occasion it was employed without being there. However, he noted that decisions taken by staff were clearly documented and regularly reviewed, and that attempts were made to keep periods of seclusion to a minimum in Ms L's case. That said, he noted that the distinction between the two types used (locking Ms L in her room and use of a separate seclusion room) was difficult to follow. Whilst upholding in part some aspects of Mrs J's concerns, the Ombudsman was satisfied from the documentary evidence that Mrs J was given the necessary and appropriate information about Tribunal appeal rights. Her detention was thus lawful and there was no interference with Article 6. Whilst noting what she said, there was no evidence that Mrs J made formal written requests to anyone for her daughter to be allowed home. The Adviser was broadly satisfied with Ms L's care – she had been prescribed antibiotics for the UTI, yet her disturbed behaviour continued, albeit the Adviser felt there was a lack of senior input into dealing with Ms L at times.

Whilst noting Mrs J's strong views, on seclusion in particular, the Ombudsman said that the threshold for Article 3 (in terms of it being degrading treatment) was not met but he went on to consider whether in the context of Article 8 it had impacted on Ms L's dignity. Given the Adviser's views, the Ombudsman was satisfied that the actions taken to seclude Ms L were necessary. Furthermore, Article 8, being a qualified right, meant that the seclusion decisions were taken not only for the purpose of protecting Ms L from harm but also in order to protect others (staff and other patients).

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