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Equality and Human Rights Casebook

2023/24

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Our role

We have three main roles:

We investigate complaints about public services.

We consider complaints about councillors breaching the Code of Conduct.

We drive systemic improvement of public services and standards of conduct in local government in Wales.

We are independent, impartial, fair and open to all who need us. Our service is free of charge.

We can provide a summary of this document in accessible formats, including Braille, large print and Easy Read.
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Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

This document is also available in Welsh.

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Foreword

This is our fifth Equality and Human Rights Casebook.

As I do every year, I must emphasise 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.

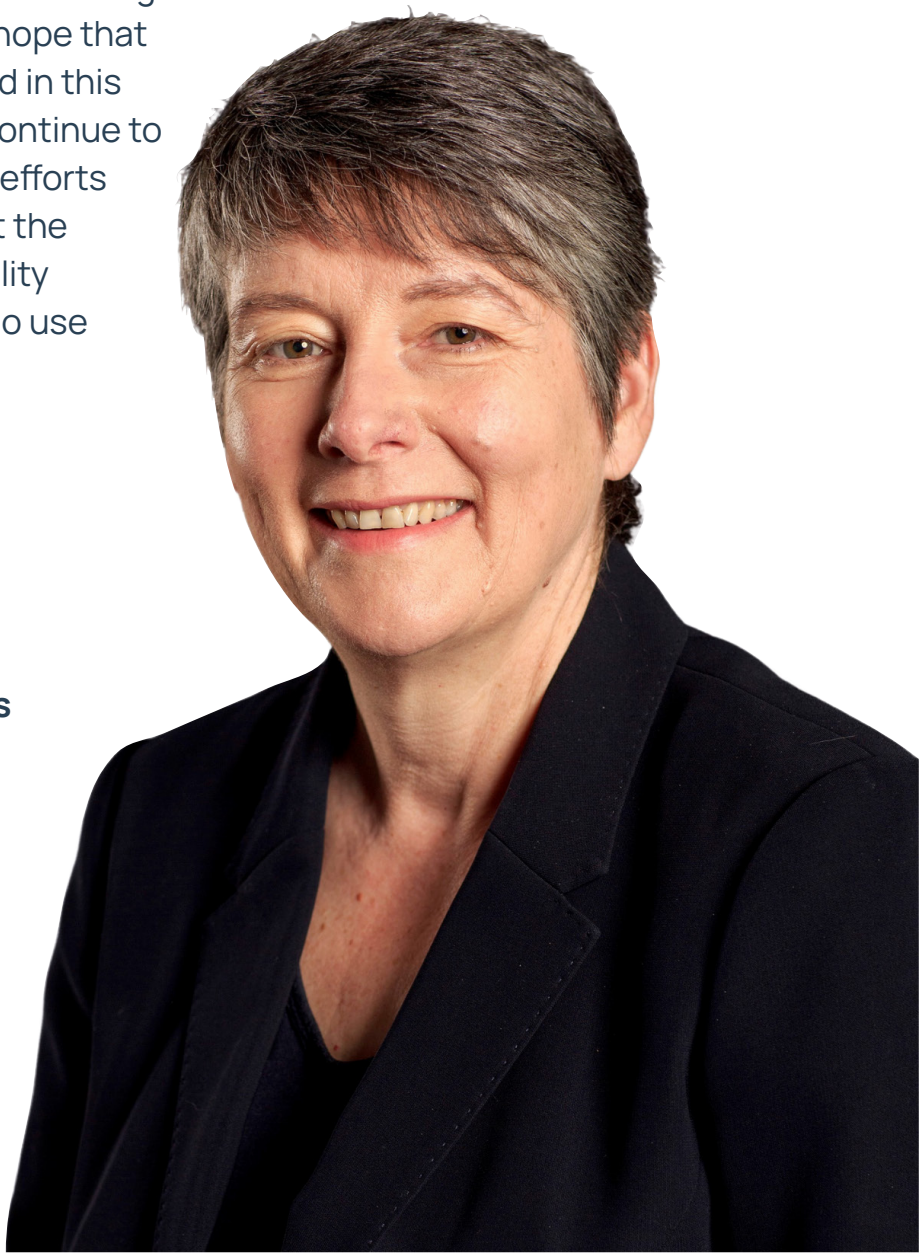
Some of the complaints we closed in 2022/23 and in the first half of 2023/2024 still related to events that unfolded during the COVID-19 pandemic and during the measures and restrictions introduced to protect public health. Continuing the theme introduced in our previous Casebooks, we present here 2 cases related to the application of the 'Do Not Attempt Cardiopulmonary Resuscitation' ('DNACPR') procedure. In both these cases, we saw that the failings we identified may have engaged Article 8 of the Human Rights Act - the right to respect for private and family life, home and correspondence.

In addition, we include several further cases in which we decided that the human rights duties of public service providers may have been engaged – or that the providers did not consider the FREDA principles of Fairness, Respect, Equality, Dignity and Autonomy – core values which underpin human rights.

The selection in this Casebook also highlights some complaints related to equality duties – predominantly, the duty to offer reasonable adjustments to disabled people. However, we also include one example of a complaint concerning services for trans people.

Although most of the cases included in this Casebook are examples of when 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 we look at.

We were glad to see our work to promote equality and human rights publicly acknowledged this year by the House of Commons and House of Lords Joint Committee on Human Rights, in the context of that Committee's inquiry into the merits of establishing a Human Rights Ombudsperson. The inquiry concluded that, given the work currently undertaken by our office and our sister organisations, there would be no merit in establishing a separate scheme. We hope that the selection presented in this Casebook will help to continue to raise awareness of our efforts 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 2023

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

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; and
- 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.

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. There are some limited rights, meaning they might be interfered with in certain circumstances (such as during 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 5 and 8.

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 had not addressed 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 2022/23 and until November 2023.

For this casebook, we have simplified and adjusted case summaries to make them more accessible and to 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 related to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

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.

202105760

Betsi Cadwaladr University Health Board

Non-public interest report

The complaint

Miss A complained to us about the care and treatment that her mother, Mrs B, received from Betsi Cadwaladr UHB.

Miss A was concerned that the Health Board made a DNACPR decision without properly consulting Mrs B or her family. She was also concerned that Mrs B's discharge and transfer to another hospital were inappropriate and that the

Health Board did not inform the family that Mrs B's condition was deteriorating, following a further hospital admission.

What we found

We found that the DNACPR decision was clinically justified, but the Health Board did not make it in line with the DNAPCR policy. There was no record of any discussion with Mrs B or her family. We recognised that the clinicians involved were working under extreme pressure at the time because of the COVID-19 pandemic. However, even considering the unprecedented circumstances, clinicians could and should have discussed the DNACPR decision with Mrs B's family.

We also found that the Health Board discharged Mrs B inappropriately. It did not do enough to ensure that Mrs B had fully recovered and had the right support in place at home.

However, we decided that the transfer to another hospital was clinically appropriate because Mrs B was in a relatively stable condition at that time. We found that, although the Health Board was regularly updating Miss A about Mrs B's condition, it did not take the right steps to arrange a visit when it was clear that Mrs B was approaching the end of her life.

What we said

The DNACPR policy stresses that the decision under the policy should be discussed and the discussion recorded. We did not see the record of that discussion with Mrs B. This went against Mrs B's rights of self-determination and choice under **Article 8 of the Human Rights Act**. Mrs B and her family also had the right for their family life to be respected and at least one family member should have been allowed to visit Mrs B before she died – even under the strict visiting restrictions during the COVID-19 pandemic.

What we recommended

We recommended that the Health Board should apologise for its failings and remind relevant staff about holding and documenting DNACPR discussions with patients and those close to them, in accordance with DNACPR Policy.

202101144

Betsi Cadwaladr University Health Board

Non-public interest report

The complaint

Mr D complained about the care and treatment his late wife, Mrs D, received in a hospital managed by Betsi Cadwaladr University Health Board.

Mr D complained that the Health Board did not communicate well with Mrs D and her family and did not offer them the right support. He also complained that Mrs D's gastroscopy (a procedure to check the upper part of the digestive system) was not appropriate and of the right standard. Mr D was also unhappy with the care planning, including discussions around a DNACPR agreement for Mrs D.

What we found

We found that the Health Board's decision to undertake a gastroscopy was reasonable and the procedure met an appropriate standard.

However, we found that the Health Board could have done more to assist Mrs D to communicate and receive support from her family, especially during difficult conversations and in relation to her DNACPR wishes. Also, the Health Board did not have enough documentation to explain why Mrs D's condition became worse.

What we said

When Mrs D could not speak for herself, the Health Board did not inform Mr D of her wishes. This meant that Mr D was not fully informed when the Health Board asked him to discuss DNACPR. We decided that this engaged **Article 8 of the Human Rights Act**, which requires the Health Board to ensure that patients can express their wishes about their care and treatment.

What we recommended

In addition to an apology to Mrs D's family, we recommended that the Health Board improves how it documents that patients have been informed of their options and the support available to communicate with family and friends.

We recommended that the Health Board reminds clinicians that patients should be able to be supported by their family or friends during difficult conversations.

Also, when patients are no longer able to speak for themselves, the clinicians should also document that they have checked what wishes the patients have expressed.

We also recommended that the Health Board audits a sample of records on the relevant ward to confirm if observations are being properly documented.

Other cases engaging human rights and FREDA Principles

202101000

Betsi Cadwaladr University Health Board

Public interest report

The complaint

Mrs F complained about the care her sister, Ms G, received from Betsi Cadwaladr University Health Board. Mrs F complained that delays in placing stents (drains) into Ms G's kidneys led to later complications with her condition and that Ms G had inadequate bowel care. Mrs F was also unhappy with how the Health Board responded to her complaints.

What we found

We found that Ms G's kidney treatment was reasonable. However, we found that Ms G did not receive the specific type of bowel care she needed as no skilled staff were available to do it. Nurses did not update doctors that it had not been done. We also found that Ms G developed new symptoms which may have meant she had a bowel blockage, but this was not considered and she was discharged home. We could not say for sure that these events contributed to Ms G's death, but they were concerning. We also found that the Health Board did not keep records well and did not investigate Mrs F's complaint openly or thoroughly enough.

What we said

'Dignified care' is a principle in the professional framework for nurses advised by the Nursing and Midwifery Council. Mrs F said that her sister was embarrassed by her bowel symptoms, and inappropriate bowel care meant there was a loss of dignity for Ms G. Ms G and Mrs F's rights under the Human Rights Act should have also been considered - specifically under **Article 8**, the right to respect for private and family life.

What we recommended

In addition to an apology and financial redress to Mrs F, the Health Board agreed to share our report with staff involved in Ms G's care. It also agreed to remind nursing staff about proper record keeping, to complete a Bowel Care Protocol and ensure enough staff are trained to carry out manual bowel evacuation. Finally, it agreed to review its complaint handling and responses in light of the NHS Wales Duty of Candour, introduced in April 2023.

Duty of Candour

The Duty of Candour is a legal requirement for all NHS organisations in Wales. It requires them to be open and transparent with service users when they experience harm whilst receiving health care.

This case has also featured in our recent Strategic Report 'Groundhog Day 2', which drew attention to ongoing issues with how Welsh Health Boards handle complaints and identify failings.

202106678

Aneurin Bevan University Health Board

Non-public interest report

The complaint

Mrs B complained about the care provided by Aneurin Bevan University Health Board to her mother, Mrs C, following her admission to hospital in October 2020. Mrs B was concerned that the Health Board did not appropriately assess and treat Mrs C's continence needs, in order to enable a timely discharge. She was also concerned that the Health Board did not involve Mrs B in discussions about Mrs C's medical needs. Finally, she complained that the Health Board did not offer the right end-of-life care to Mrs C.

What we found

We found that the Health Board did not consider how to manage Mrs C's constipation and provide earlier treatment that might have eased her symptoms. We also found that the Health Board did not communicate appropriately with Mrs B, which negatively affected her care. However, we did not uphold the complaint about Mrs C's end-of-life care because we found that her care was appropriate and in keeping with relevant guidance.

What we said

The Health Board's failures in record keeping, care planning and communication meant that aspects of the care provided to Mrs C were not in keeping with the **FREDA principle of Dignity**. The failure to update Mrs B appropriately was also not in keeping with the **FREDA principle of Respect**, because it reflected a lack of concern for her needs and rights as a loved one and advocate for her mother.

These failings were concerning because of the important role that FREDA principles play in ensuring that health care is delivered in a way that protects the human rights of patients and their families.

What we recommended

The Health Board agreed to apologise to Mrs B. It also agreed to remind all nursing staff in the relevant wards that it is important to assess the needs of patients with dementia on admission and ensure that patients who are unable to express their own needs are offered a drink regularly.

The Health Board also agreed to remind all doctors working in these wards to adequately consider how to manage the bowel health of patients, as well as to communicate regularly with family members or carers of patients who cannot express their own needs.

202105404

Welsh Ambulance Services NHS

Non-public interest report

The complaint

Ms A complained about the service her late father, Mr D, who lived with dementia and schizophrenia, received from Welsh Ambulance Services NHS, after a suspected stroke.

She said that the first ambulance crew that attended should have taken her father to hospital. She was also concerned that the second ambulance crew that attended and took her father to hospital did not do enough to respect her father's dignity. Mr D was not dressed on his lower half and the blanket that he was wrapped in fell away during his transfer to the ambulance.

Ms A also said that the first ambulance crew's decision not to take Mr D to hospital meant that he was not investigated or treated well enough for a suspected stroke.

Finally, she was unhappy with how Welsh Ambulance Services NHS handled her complaint.

What we found

We found that there was not enough evidence to show that Welsh Ambulance Services NHS considered different options to transfer Mr D to the ambulance with dignity.

We also found that because there was a delay before Mr D was admitted to hospital, this delayed his stroke being investigated. Although this would not have changed the clinical outcome for Mr D, it might have avoided the later deterioration in his condition.

Finally, we found that Welsh Ambulance Services NHS could have handled Ms A's complaint better, by identifying learning from how it attended Mr D.

What we said

Mr D's transfer was not in keeping with **the FREDA principles**, nor the Health and Care Professions Council's standards of proficiency for Paramedics which stress the need for "the utmost regard for dignity at every stage".

What we recommended

Welsh Ambulance Services NHS agreed to apologise to Ms A. It also agreed to develop and implement an action plan to ensure it learns from the issues related to assessment of stroke patients, maintenance of dignity, documentation and risk assessments.

202204038

Betsi Cadwaladr University Health Board

Non-public interest report

The complaint

Ms Y complained about the care and treatment she received from Betsi Cadwaladr University Health Board during her labour.

She complained that staff did not listen to her and that her rights in relation to patient choice were withheld. She complained that she was not adequately prepared for labour and should not have been booked in to be induced.

She also complained that the complaint response she received from the Health Board was inadequate, did not fully address her concerns and incorrectly stated she was satisfied with the proposed resolution.

What we found

We found that it was reasonable that Ms Y was booked in to be induced. However, we found that the Health Board did not respect Ms Y's views and wishes during her labour and so withheld her right to choose.

We also found that the complaint response Ms Y received was very brief, not in line with guidance and did not fully address the concerns that Ms Y had raised. This caused further injustice to Ms Y as it caused her to feel again that she had not been listened to.

What we said

Ms Y consistently said that she wanted a caesarean section during her labour, while in pain and distress. The Health Board did not act on this as it should have. The Health Board did not follow the consent process when taking Ms Y into theatre and, despite her wishes, did not put up a screen during examination. These failings were not in keeping with the **FREDA principle of Autonomy** as Ms Y was not supported to make choices about her care and treatment.

What we recommended

The Health Board agreed to apologise to Ms Y and pay her a sum of money as financial redress. It also agreed to share our findings with relevant staff, review how it trains staff to respect patient wishes and review its complaint handling of this case, to identify learning points.

202105742

Betsi Cadwaladr University Health Board

Non-public interest report

The complaint

Mrs J complained about the actions of Betsi Cadwaladr University Health Board in supporting her sister, Miss M. Mrs J was unhappy with the actions of the Learning Disability (LD) Team, when asked to assist to move Miss M from the upstairs of her home to a new home, with Mrs J and her family. Mrs J also complained that her complaint was investigated by a member of Health Board staff who was the subject of her complaint.

What we found

We found that the LD Team initially acted as it should have. However, there was no urgency on the part of professionals to help Miss M move and the situation was allowed to "drift" for far too long. Although the Health Board staff could not physically help to move Miss M, they should have ensured Mrs J understood this. However, the evidence did not show that this was explained to Mrs J. We also found that Mrs J could rightly have the impression that the Health Board did not consider her complaint objectively.

What we said

Miss M had mild learning disabilities and Down's Syndrome. She was anxious about leaving her room and going downstairs and her family needed assistance from the Health Board ahead of their house move. Because of the failings we identified, Miss M was unable to participate in family life and other activities for a longer time and we decided that this meant that her human rights under **Article 8** were engaged.

What we recommended

The Health Board agreed to apologise to Mrs J and pay her financial redress for the distress caused. It also agreed that members of the LD Team involved in Miss M's care would reflect on our findings and consider what lessons can be learned.

202305161

Pembrokeshire County Council

Early Resolution

The complaint

Mrs A complained that, although Pembrokeshire County Council told her that it would investigate the damp in her property during the summer of 2022, it did not. Further, Mrs A said that the Council had not responded to her emails about the issue.

What we found

We found that, in June 2022, the Council advised Mrs A that it would be carrying out an inspection of her property during that summer. It committed to recording moisture readings to establish if there was genuine damp within the property, rather than mildew and mould caused by condensation.
We saw no evidence that that inspection had taken place.

We also found that the Council did not respond to a complaint submitted by Mrs A in September that year, as it should have done, in line with its complaints policy.

What we said

We noted that, according to the Council's policy on housing repairs, routine repairs should normally be carried out within 35 days. We understood that there could be some delay, given that an inspection was needed which would likely have to be carried out by an external company. Nevertheless, a delay of 16 months was not acceptable.

Although we did not state this when issuing our decision, arguably the failings in this case and the impact on Mrs A could be relevant to **Article 8** – right to respect for private and family life, home and correspondence.

What we recommended

We resolved this case without a full investigation. The Council agreed to apologise to Mrs A and respond to her complaint.

It also agreed to undertake a full inspection of Mrs A's property to record moisture readings, with a view to identifying the cause of the damp.

Finally, it agreed that, within 10 working days, it would tell Mrs A about the findings of the inspection, together with providing a proposed plan of works to address the cause of the damp, as necessary.

A case related to gender services

202201054

A GP Practice in the area of Cwm Taf Morgannwg University Health Board

Early Resolution

The complaint

Ms D complained about the service received when she registered with the GP Practice, having moved to the area from outside Wales.

In March 2022, Ms D, a transgender patient, requested a repeat prescription for various medication, including Hormone Replacement Therapy (HRT) medication. The Practice declined to prescribe the HRT medication and instead made a referral to the Wales Gender Service.

What we found

We found that the Practice had broadly acted in accordance with referral and prescribing guidance in place with the Welsh Gender Service. However, in taking a cautious approach and making a new referral, Ms D was left without the medication required for her to maintain a healthy hormone balance for several weeks.

There was some poor communication with Ms D as to the reasons for the referral being necessary, which caused upset and distress. We found that the Practice could have contacted the Welsh Gender Service for advice on prescribing to clarify the position by email and could have done so sooner, which may have avoided Ms D being without medication or at least minimised any delay.

What we said

Ms D contacted us because she considered that the GP's approach regarding her HRT medication was discriminatory. However, we had to be mindful that the GP Practice was following the guidance set out by the Welsh Gender Service.

Our Adviser in this case noted that there was no specific pathway for the care of a patient who registers in Wales having been treated outside Wales. For this reason, although we made some recommendations for the GP Practice, we also raised this issue with the Welsh Gender Service, separately.

What we recommended

We decided to settle the complaint without an investigation. The Practice agreed to apologise to Ms D for the delay in clarifying matters with the Welsh Gender Service and issuing a prescription.

It also agreed to meet with Ms D to discuss her concerns and experience with a view to reinstating her as a patient with the Practice.

Finally, it agreed to discuss the matter in a clinical meeting and inform all GPs of the informal facility to seek advice on prescribing from the Welsh Gender Service, by email.

Cases related to reasonable adjustments

Reasonable adjustments

Under the Equality Act, service providers must provide reasonable adjustments to disabled people. Providing reasonable adjustments means that organisations must take positive steps to remove the barriers people face because of their disability.

202300591

Bron Afon Community Housing Ltd

The complaint

Ms B complained to us through an advocate that the Housing Association's Adaptations Panel (AP) declined to fund works to adapt her home, to enable her disabled daughter to remain at her property.

She was concerned that the family was not given a reasonable opportunity to directly make their case to the Panel and that their views were disregarded.

She was also concerned that, by declining to fund and undertake some of the requested work, the Panel disregarded the family's rights under the Equality Act.

What we found

We saw evidence that the family's wishes had been fully considered as part of the AP's decision-making process and were not "disregarded". There is no procedural right to directly speak in person to the AP. In our view, the Housing Association appeared to have evaluated what options would be cost-effective and appropriate, in relation to their wider housing stock, and did so in line with its policy and guidance.

What we said

Overall, we found that the decision of the Housing Association appeared to be compatible with the principles of the Equality Act 2010, as requests for adaptation may be refused if deemed unreasonable.

However, we noted that, although the Housing Association appeared to have considered its duty to provide reasonable adjustments, its criteria and guidance was dated 2009.

Therefore, it needed to be updated to incorporate and reflect newer and relevant legislation, including the Equality Act.

What we recommended

We asked the Housing Association to consider updating its criteria and guidance considering the Equality Act and preparing an Equality Impact Assessment.

202107242

Aneurin Bevan University Health Board

Non-public interest report

The complaint

Mrs A complained about the care she received from Aneurin Bevan University Health Board at Nevill Hall Hospital during various stages of her pregnancy and postnatal care. She also complained that she did not receive support with breast feeding and skin-to-skin contact with her son following his birth.

Mrs A was also concerned about the neonatal unit's visiting rules and that the Health Board did not make reasonable adjustments for her, despite her mental health condition.

Finally, Mrs A complained that the Health Board did not handle her complaint well.

What we found

We upheld Ms A's complaints. We found failings in relation to pain management (in early labour) and communication with Ms A. We also found that the Health Board could have done more to support Ms A with breastfeeding and skin-to-skin contact.

When applying its neonatal visiting arrangements, the Health Board did not consider Ms A's right to reasonable adjustments.

We also found that the Health Board did not handle Ms A's complaint well enough and did not consider its equality duties in its response.

What we said

Ms A's disability meant that the Health Board had a statutory duty to support her under the Equality Act 2010. The Health Board should have been able to show that it considered making reasonable adjustments for Ms A.

We were concerned that, apart from isolated episodes, there was little evidence that the Health Board considered reasonable adjustments or whether the visiting guidance applied, in this case.

What we recommended

The Health Board agreed to apologise to Ms A. It agreed to share our report internally with its Equality Officer and to organise training to maternity staff on reasonable adjustments.

The Health Board also agreed to involve its Equality Officer during the complaints process, when complainants raise issues around reasonable adjustments.

202203628

Hywel Dda University Health Board

Non-public interest report

The complaint

Ms Y complained about the care and treatment provided by Hywel Dda University Health Board to her mother, Mrs J, when she was in hospital.

Ms Y complained that the Health Board did not thoroughly assess her mother's needs and missed opportunities to involve the Specialist Palliative Care Team. She also complained that clinical staff had not recognised the deterioration in Mrs J.

Ms Y was also concerned that the Health Board did not make reasonable adjustments to make sure that Mrs J, who had a hearing impairment, understood information and was able to express her views.

What we found

We found that the Health Board missed opportunities to involve the Specialist Palliative Care Team in Mrs J's care and to support her family. Because of this, for some time, Mrs J did not have enough pain relief.

We also found that, although staff discussed her care and treatment with Mrs J, there was no evidence that staff ensured that Mrs J was wearing her hearing aids. There was also no evidence that staff considered if Mrs J needed any other adjustments to help her communicate and understand information.

What we said

Mrs J was unwell, in an unfamiliar environment and, at times, without her family present to support her. She was not always wearing her hearing aids and her family raised concerns with staff about her ability to understand information that was shared with her.

Under the Equality Act 2010, public sector organisations are required to make reasonable adjustments for disabled people, including those with a hearing impairment.

Based on the evidence we saw, it was not possible to be sure that staff checked if Mrs J was wearing her hearing aids or needed any other adjustments. This was an injustice to Mrs J and her family.

What we recommended

The Health Board agreed to apologise to Ms Y. It also agreed to sharing our findings with relevant clinical staff and to update us about what it would do to improve internal communication with the Specialist Palliative Care Team.

The Health Board also agreed to review how it supports people with a hearing impairment and how this is documented in a patient's notes.

202102222

Aneurin Bevan University Health Board

Non-public interest report

The complaint

Mr A complained that Aneurin Bevan University Health Board did not consider his complex mental health needs (due to Post Traumatic Stress Disorder (PTSD) and Asperger syndrome) when treating him at the Royal Gwent Hospital in June 2020.

He also complained that the Health Board did not discharge him safely and did not provide appropriate support to him through the community mental health team.

Finally, he said that the Health Board did not respond to his complaints appropriately.

What we found

We found that the Health Board had provided appropriate and sufficient mental health support for Mr A and that it had taken appropriate action in taking account of Mr A's complex mental health needs. Mr A's discharge was also appropriate.

However, we agreed that the Health Board took too long to respond to Mr A's complaints and did not fully address his concerns. This was, at least in part, because the Health Board lost some of Mr A's hospital records.

What we said

When considering this case, we recognised that PTSD and Asperger syndrome could be viewed as disabilities under the Equality Act 2010 (although it was not our role to determine if that was the case for Mr A).

We noted that Mr A had not specified the reasonable adjustments he was seeking or expecting from the Health Board. However, the duty to provide reasonable adjustments is 'anticipatory', which means that clinicians should have been alert to the possibility that Mr A may have additional needs.

We saw evidence that clinicians recognised that Mr A had PTSD and Asperger syndrome when he was seen at the hospital. However, although some adjustments for Mr A were made, we decided that the Health Board could make improvements.

What we recommended

We invited the Health Board to consider Mr A's future need for reasonable adjustments. More generally, we invited it to review how it identifies disabled patients promptly when they attend the ED and how it considers and addresses the possibility that they might have additional needs because of any disability identified.

We also recommended that the Health Board apologised for the complaint handling failings, paid him redress and took action to try and reduce the risk of misplacing records in future.

202102508

Aneurin Bevan University Health Board

Non-public interest report

The complaint

Mr B complained about the care and treatment provided by Aneurin Bevan University Health Board to his late wife, Mrs B, when she was admitted to 2 hospitals.

Mr B questioned why Mrs B was moved to a COVID-19 ward when tests showed she was "low positive" for COVID-19 and why she was given insulin when her blood sugar level was low.

Mr B complained that Mrs B's blood transfusion caused an adverse reaction, as the blood did not match Mrs B's ethnicity.

He said that the Health Board did not communicate with him and Mrs B about her needs. The Health Board used a service called 'language line' to interpret for Mrs B. Mr B felt that service was not effective and the Health Board should have used its own staff who spoke Nepali. He said his wife told him she could not understand what doctors and nurses were saying. He said that the nurses may have been "racist".

Finally, Mr B complained that the Health Board did not handle his complaint well.

What we found

We found that the Health Board was right to move Mrs B to a COVID-19 ward when she developed a temperature. The Health Board took the right steps to test Mrs B for COVID-19.

We also found that Mrs B was treated appropriately with insulin. We also found no evidence that there were complications or side effects from Mrs B's blood transfusion and donor bloods were tested against Mrs B's blood sample for matching.

However, we found that the Health Board did not communicate with Mrs B and Mr B as well as it should have. Although we decided that, overall, the Health Board responded to Mr B's complaint well, we noted that it did not identify those failings around communication. This meant that it missed opportunities to learn lessons.

What we said

We decided that the Health Board followed its policy on language and interpreting services and that it was right to use 'language line'. However, overall, we found that communication with Mrs B's family was not as effective as it could have been.

What we recommended

The Health Board agreed to apologise to Mr B for the failings which we identified.

Appendix - the Articles of the European Convention on Human Rights

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, or 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 (and 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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