

The investigation of a complaint
By Mrs A
against Cwm Taf University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201703374

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs A, and the aggrieved as Mr B.

Summary

Mrs A complained that the Health Board delayed in providing her son, Mr B, with appropriate and timely mental health and autism spectrum disorder (“ASD”) assessments. She also complained about the Health Board’s failure to provide her with a robust response to her complaints.

In 2015, a Crisis Team assessed Mr B’s psychiatric and psychological needs and referred him for both ASD and mental health assessments. My investigation found that the Health Board’s practice of referring patients for ASD assessment prior to a referral for a mental health assessment was contrary to guidance and good clinical practice. In Mr B’s case, his ASD assessment was not completed until May 2017. During this time, the Health Board failed to take any action to either consider, or provide for, Mr B’s mental ill health. It was therefore two years before his mental health needs were assessed.

The Health Board’s care fell below expected standards, good clinical practice and guidelines in terms of its lengthy delay in completing Mr B’s ASD assessment, its failure to consider Mr B’s co-existing mental health needs, and its failure to refer Mr B for a mental health assessment at the same time as his ASD referral. It was not possible to determine whether Mr B’s situation would have been different had the Health Board’s failings not occurred, but it caused him uncertainty and distress. His human rights under Article 8¹ were engaged as a consequence of the Health Board’s identified failings.

When the first Community Mental Health Team (“CMHT”) finally assessed Mr B’s mental health needs, it concluded that Mr B should be accepted for secondary mental health services. Mr B changed address soon after this assessment and had to be assessed by the second CMHT. This concluded that Mr B was not eligible for secondary mental health services. The investigation was unable to reconcile the differing decisions of the two CMHTs within the same Health Board and only six weeks apart.

¹ Article 8 of the Human Rights Act 1998 provides the right to respect for an individual’s private and family life, home and correspondence.

The Health Board's complaints response failed to address some of Mrs A's specific concerns.

The Ombudsman upheld Mrs A's complaints and made recommendations which were accepted by the Health Board. These included:

- a) Financial redress payments and appropriate apologies to both Mrs A and Mr B for the failures identified.
- b) A review of current practice to ensure it follows guidelines to allow patients with dual ASD and mental health needs to be assessed concurrently.
- c) An audit of a sample of patients who had been referred for ASD and mental health assessments to ensure others had not been similarly disadvantaged.
- d) An audit of a sample of mental health assessments from both the first and second CMHTs for a consistent application of the criteria for access to secondary mental health services.
- e) A reassessment of Mr B's mental health needs and eligibility for secondary mental health care services.

Complaint against Cwm Taf University Health Board

The Complaint

1. Mrs A complained that Cwm Taf University Health Board (“the Health Board”) delayed providing her son, Mr B, with appropriate and timely mental health and autism spectrum disorder (“ASD”) assessments. Mrs A also complained about the Health Board’s complaints handling and a failure to provide a robust response to her complaint.

Investigation

2. I obtained comments and copies of relevant documents from the Health Board, which I considered in conjunction with evidence provided by Mrs A. I obtained clinical advice from one of the Ombudsman’s Professional Advisers, Dr Asit Baran Biswas, an experienced Clinical Psychiatrist (“the Adviser”).

3. All relevant guidance was considered, in particular I had regard to:

- a) National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Putting Things Right: Guidance on dealing with concerns about the NHS (“PTR”). This sets a timescale and procedure for Welsh NHS bodies (“the body”) to follow when considering complaints. Where a body’s investigation of a complaint identifies a breach of its duty of care which results in harm to a patient then a ‘qualifying liability’ arises.² Under PTR, a Regulation 24 complaint response is issued where the body’s investigation concludes no qualifying liability is owed to a patient, whereas a Regulation 26 response concludes that a qualifying liability does arise. Further, PTR sets out the information which should be included in a body’s final complaint response; this should include details of the investigation of the complaint, whether a qualifying liability is owed to the patient when harm is alleged, a rationale for any decisions reached and should inform the complainant of the right to escalate the complaint to the Ombudsman.

² To establish a ‘qualifying liability’ evidence of two factors is required: firstly, that the care/treatment fell below reasonable and accepted standards, and secondly, the identified failing resulted in the patient suffering injury or harm.

b) The Human Rights Act 1998 (“the HRA”) provides that public bodies, such as the NHS, are required to act in compliance with the rights set out as Articles in the HRA and to respect and protect those human rights. Article 8 is the right to respect for an individual’s private and family life, home and correspondence.

4. In this report I have summarised key events, views, and the clinical advice received. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

5. Both Mrs A and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Background information and events

6. On 26 May **2015**, Mr B was assessed by a Mental Health Crisis Team (“the Crisis Team”) which noted his severe panic attacks, self-harming, depression, suicidal thoughts and increased anxiety which he self-medicated with significant volumes of alcohol. The Crisis Team documented that a destabilisation in Mr B’s mental health was likely and he displayed possible autistic characteristics, and they referred him to Primary Care Mental Health Support Service (“the PCMHSS”) for anxiety management and possible ASD. Mrs A said that, at Mr B’s preliminary assessment by PCMHSS on 6 July, he was told an ASD diagnosis usually takes three appointments and is undertaken by primary care, but that mental health assessments are undertaken by secondary care and that Mr B could not be treated by both teams at the same time. Mr B subsequently agreed to undergo an ASD assessment first, after which he would be referred for a mental health assessment.

7. Mr B’s first ASD appointment was more than a year later with an Advanced Practitioner (“the first Practitioner”) on 10 August **2016**. Thereafter, six of Mr B’s arranged appointments were cancelled due to the first Practitioner’s absence from work. However, Mr B attended three ASD appointments with the first Practitioner between November and December, but the Health Board said there were no clinical records for these consultations.

8. On 30 December, Mr B's ASD assessment was started afresh with a different Advanced Practitioner ("the second Practitioner"), and he was also referred to the Community Drug and Alcohol Team ("CDAT") for his alcohol dependency. The CDAT noted that Mr B had suffered depression and anxiety since his early teens and had been prescribed anti-depressants for a significant part of his life. A letter from the CDAT Psychiatrist to Mr B's GP, noted that Mr B's anti-depressant medication helped him to the extent that he no longer self-harmed but did not benefit his anxiety or mood. The CDAT Psychiatrist confirmed that he informed Mr B that once his ASD assessment was completed he could be referred for a mental health assessment.

9. Mr B had three ASD appointments with the second Practitioner between January and March **2017** and he saw a Consultant Clinical Psychologist ("the first Psychologist") twice. In March, Mrs A complained to the Health Board, via her Community Health Council Advocate ("the Advocate"), under PTR. Mrs A met Health Board staff on 28 March and at this local resolution meeting she relayed her concerns about the delays in Mr B's ASD assessment and deterioration in his mental health, but instead of pursuing her concerns at that stage she agreed to await the outcome of Mr B's appointment with the first Psychologist the next day, in the hope he would be given a diagnosis. The next day, Mr B did not have a diagnosis and, following a breakdown in communication with the first Psychologist, Mrs A complained to the Health Board via her MP. Mrs A was concerned that Mr B's ASD assessment was still not completed, that he did not have a diagnosis, and that he had lost trust in the first Psychologist and the Health Board.

10. Mr B's ASD assessment was completed on 11 May by a different Psychologist ("the second Psychologist") which concluded that Mr B met the diagnostic criteria for adult ASD and recommended Mr B's referral for a mental health assessment. On 18 May, the Advocate emailed the Health Board for an update on the complaint. On 21 June, Mrs A met Health Board staff and discussed her concerns about the delays in Mr B's ASD assessment and highlighted that his mental health had significantly deteriorated during that period. In the Health Board's letter of even date, it apologised to Mrs A that the service received was not as expected, assured her that Mr B's referral for a mental health assessment would

be actioned and that a Community Mental Health Team (“CMHT”) would be in touch shortly with an appointment. A CMHT (“the first CMHT”) received Mr B’s mental health referral on 26 June. In July, Mr B was discharged from CDAT because of his continued progress in controlling his alcohol consumption.

11. The Health Board responded to Mrs A’s MP’s complaint in a letter dated 6 July, which was copied to Mrs A and her Advocate, but no notes of the local resolution meeting were provided. The Health Board apologised for the communication issues between Mrs A and the first Psychologist and acknowledged the distress events had caused both Mrs A and Mr B but concluded that no qualifying liability was owed to Mr B because he suffered no significant harm as a result of the care provided. The Advocate submitted Mrs A’s complaint to the Ombudsman.

12. Mr B was assessed by the first CMHT on 12 September when it was noted that Mr B’s antidepressants benefitted him in terms of managing his suicidal thoughts but had little other benefit. Mr B’s risk assessment noted his risks of self-harm, self-neglect and suicidal thoughts. The first CMHT recommended that Mr B be accepted for secondary care mental health services and highlighted that Mr B’s anxiety reactions exceeded the usual problems of ASD functioning. The first CMHT explained to Mr B that it could not accept him as a patient because he had recently moved out of its area, and it referred him to a CMHT in the area in which he resided (“the second CMHT”); both CMHTs come within the Health Board’s area.

13. On 31 October, the second CMHT decided Mr B did not meet the eligibility criteria for secondary care mental health services because his needs related to his ASD. The Health Board was asked to reconsider that decision as Mr B felt he required support for his mental health needs, and on 3 November, the second CMHT informed Mr B that he was not eligible to receive secondary care mental health services and the original decision remained unchanged.

Mrs A's evidence

14. Mrs A said she witnessed Mr B struggle to function in society for many years, he had sunk into a deeper depression, attempted suicide and lived in virtual isolation. In sheer desperation, Mrs A said she took Mr B to the Crisis Team in May 2015 and thought he might get the support he required, but there were continual and lengthy delays in his ASD assessment which was completed two years later, in May 2017.

15. Mrs A said during these two years the Health Board failed to provide Mr B with any mental health support. Mrs A said that despite Mr B's significant mental health deterioration, the Health Board maintained it could not deal with Mr B's mental health assessment until his ASD assessment was completed. She said throughout his life Mr B had been unable to manage his own mental health needs, his family were not equipped to provide the support required to meet his mental health needs and she remained very concerned about who would support him when she died. Mrs A said she was exhausted in attempting to progress appropriate assessments for Mr B's mental health and ASD needs, and the only future she could see for Mr B was that of a recluse existing in a cardboard box in a shop doorway. Mrs A said that scenario was not far away from his current existence of seclusion, with industrial ear defenders to block out everyday life and a diet of ineffective antidepressants and alcohol.

16. Mrs A said the Health Board failed to complete Mr B's ASD and mental health assessments in a timely manner, which added to his distress, and that the continued pressure on him throughout these years was immeasurable. Mrs A considered that the Health Board systematically failed, and continues to fail, Mr B, that his mental health needs had not been met and that this had hampered her attempts to give him any sort of future.

17. Mrs A said the Health Board's poor complaints handling only added to both her and Mr B's distress. She said she was frustrated and disappointed by the complaints process and the Health Board's lack of a proper response to her concerns. Mrs A said the Health Board had made her feel powerless to help her son, Mr B, to obtain the support required to meet his needs and allow him to function in society.

The Health Board's evidence

18. The Health Board said that when a person with suspected ASD is referred for assessment, his/her initial ASD assessment should start within 28 days of referral. It said that when the initial assessment concludes that a detailed three stage ASD assessment is required, the patient would be allocated a trained professional. It said the First Practitioner was the only trained professional to undertake ASD assessments in Mr B's locality at that time, and he had unforeseen and very difficult personal circumstances to manage which led to delays in Mr B's ASD assessment and several of his appointments were cancelled. The Health Board said due to subsequent issues between Mrs A and the first Psychologist there was a further delay in completing Mr B's ASD assessment.

19. The Health Board said that during Mr B's ASD assessment it had not received a request for additional mental health support for him, that PCMHSS does not provide a monitoring service and CDAT were in regular contact with him. The Health Board said Mr B was referred for a mental health assessment once his ASD assessment was completed. It recognised this was a limited resource with significantly increasing demand.

20. The Health Board acknowledged that Mr B's ASD assessment was completed in May 2017, and he was referred for a mental health assessment. However, it was decided that Mr B did not meet the threshold for CMHT support, so he was not offered any services.

21. The Health Board noted Mrs A's concerns about its complaints handling. It explained that where a complainant chose to accept an offer to meet Health Board staff instead of receiving a written response, its usual practice is to facilitate the meeting and send a copy of the meeting notes with a covering letter. It said this happened in Mrs A's case and as such its letters to Mrs A and her MP were not intended to be its formal PTR response; it was the meeting notes in combination with the covering letter that was its PTR response. The Health Board explained that meeting notes briefly summarise outstanding concerns and agreed next actions and reiterate any apologies; the covering letter includes the required PTR paragraph about any qualifying liability. The Health Board said this happened in Mrs A's case.

Professional Advice

22. The Adviser considered Mr B's clinical records, and the complaint documentation, to review the care Mr B received. The Adviser referred to two relevant pieces of guidance which relate to good clinical practice. These are:

- National Institute of Health and Care Excellence (NICE) Clinical Guideline 142: Autism spectrum disorder in adults: diagnosis and management³ (Issued in 2012; updated in 2016)
- NICE Quality Standard 51.⁴

23. The Adviser said Mr B's ASD referral was actioned in a timely manner and his ASD assessment followed relevant NICE guidelines. However, the Adviser noted that delays to Mr B's ASD assessment were caused partly by the Health Board's cancellation of several appointments due to staff unavailability and by possible resource constraints, which did not allow alternative arrangements to be made. The Adviser was concerned that Mr B's ASD assessment was not completed until May 2017, and Mr B's mental health assessment could not be actioned until the ASD assessment was completed.

24. The Adviser also noted that Mr B was not referred for a mental health assessment at the same time as he was referred for an ASD assessment. The Adviser expressed concern about the Health Board's practice of referring patients with ASD and mental health assessments to only one team at a time, as in Mr B's case. The Adviser said this practice is not in accordance with NICE guidance nor with good clinical practice.

25. The Adviser said that in August 2016, Mr B presented with several psychiatric symptoms which could not solely be attributed to ASD. The Adviser said guidance recognised the complex needs of patients with ASD and the need for additional support. The Adviser said Mr B's care plan should have included additional support for his mental health needs, a risk management plan and a contingency plan for Mr B's potential crisis. The Adviser said this was not done.

³ <https://www.nice.org.uk/guidance/cg142/chapter/1-Guidance>

⁴ <https://www.nice.org.uk/guidance/qs51>

26. The Adviser concluded that the Health Board's overall care and treatment provided to Mr B, in particular the mental health assessment and treatment, and management of his risks and crisis, fell short of expected national standards.

27. The Adviser suggested that, unless the Health Board has already done so, it should note and follow NICE guidance for ASD and co-ordinate with its partner agencies, such as social services, the National Autistic Society, and family and service user groups, to promote local care pathways which provide access for all adults with ASD and include those patients with co-existing mental disorders.

Analysis and conclusions

28. In reaching my conclusions I have carefully considered all the information provided and been guided by the Adviser's views on the clinical aspects of the complaint. However, the conclusions reached in this report are mine.

29. My role is to consider whether the Health Board's care fell within acceptable clinical standards based on information reasonably known at the time of events complained about. To uphold a complaint, I must be satisfied that any identified failing, by the Health Board, directly caused Mr B or Mrs A an injustice.

30. Mrs A raised concerns about Mr B's ASD and mental health assessments and the care provided to Mr B. The Adviser has provided his comments on the Health Board's care provided to Mr B at paragraphs 22 to 27 of this report; I will not reiterate those points here.

31. In May 2015, the Crisis Team assessed Mr B's psychiatric and psychological needs and referred him to PCMHSS for both ASD and mental health assessments. Based on the evidence provided, I am satisfied that the Health Board's care fell below expected standards, good clinical practice and guidelines in Mr B's case. Firstly, whilst Mr B's PCMHSS assessment was in July 2015, he waited for over a year until August 2016, for his first ASD appointment. Thereafter, several appointments were cancelled, and no notes were made of three consultations. In total, there was an unacceptable two-year delay

in completing Mr B's ASD assessment. This was coupled with a failure to consider Mr B's co-existing mental health needs. I was disappointed to note that, despite Mrs A's continual concerns about Mr B's significant deterioration in his mental health during that two-year period, the Health Board and its clinicians maintained its view that it could not refer patients like Mr B, who required both ASD and mental health assessments to two teams at the same time. This practice is clearly contrary to NICE guidance and good clinical practice.

32. I am mindful of the Health Board's comments at paragraph 19 above, namely that it did not receive a request for additional mental health support for Mr B and he was in contact with CDAT during the relevant period. I have seen several entries in Mr B's clinical records where he raised concerns about his mental health needs and his ineffective antidepressant medication, but clinicians involved in Mr B's care maintained the Health Board's view that Mr B would not be referred for a mental health assessment until his ASD assessment was completed. Such a situation is likely to have occurred with any other patients who needed dual care and treatment like Mr B. The Health Board's practice is clearly not acceptable and fails to meet the needs of some of the most vulnerable in our society. In my view, it is imperative that the NHS give an equal priority to meet an individual's mental health needs as it would to any other clinical needs. In Mr B's case, I was disheartened that despite Mr B raising concerns about his own mental health and his antidepressants, the Health Board took no action.

33. I am satisfied that the events caused Mr B an injustice, in terms of the lengthy delay in completing his ASD assessment, the failure to consider Mr B's co-existing mental health needs and the failure to refer him for a mental health assessment at the same time as his ASD referral. Accordingly, I **uphold** this complaint.

34. Mr B was eventually assessed by the first CMHT. The first CMHT recommended that Mr B be accepted for secondary mental health services as it concluded that his current needs exceeded the usual ASD reactions. Following a change of address soon after the assessment, Mr B was assessed by the second CMHT. The second CMHT concluded that Mr B was not eligible for secondary mental health services as his needs related to his ASD.

35. Both CMHTs fall within the Health Board's area and would use the same criteria to assess whether an individual is eligible for secondary mental health services. The records show that the first CMHT met Mr B and provided a detailed assessment of his mental health needs, but I can find no evidence that the second CMHT met Mr B to fully assess his clinical need. I am unable to reconcile the differing decisions of the two CMHTs, in the same Health Board and applying the same criteria, only six weeks apart. In these circumstances, I consider that the Health Board should reassess Mr B's mental health needs to determine his eligibility for secondary care services and I have included this as a recommendation.

36. I next consider Mrs A's complaint handling concerns. Based on the information provided I am satisfied that the Health Board's response of 6 July falls short of PTR requirements as it failed to respond to Mrs A's specific concerns about Mr B's mental health support. I note the Health Board's comments (paragraph 21) about its usual PTR response when a complainant attends a meeting with clinicians rather than receiving a written response. However, its covering letter did not refer to Mrs A's right to escalate her complaint to my office and failed to include the meeting notes of 21 June. Whilst I recognise the impact of this failure to Mr B was mitigated to the extent that Mrs A was represented by an Advocate who subsequently directed her complaint to me, I am satisfied that Mrs A was put to unnecessary additional time, and was caused additional frustration and distress, in trying to resolve her concerns about Mr B's unmet needs. I therefore **uphold** this element of Mrs A's complaint.

37. Finally, and whilst not specifically raised in Mrs A's complaint, I have considered the impact of the Health Board's failures above on Mr B's human rights. I have a role in promoting the human rights of ordinary people in their dealings with public services in Wales. Mr B was a vulnerable individual, his needs and wishes should have been properly considered by the Health Board and he should have been treated with fairness, respect, equality, dignity and autonomy.

38. Where I find evidence of service failure which directly caused an individual injustice, it is appropriate for me to consider whether the person's human rights have been compromised.

39. The Health Board failed to consider and provide for Mr B's mental health needs for over two years from his initial assessment by the Crisis Team in 2015. The ASD assessment itself took almost two years to complete which was inordinately prolonged. During this time Mrs A and Mr B, himself, raised his need for assistance with his mental health, but the Health Board would not depart from its rigid practice that patients such as Mr B could not be treated by two clinical teams at the same time, despite this view being contrary to NICE guidance.

40. Mr B suffered the indignity of not having a family life, or indeed any apparent quality of life, during this period, despite the 2015 referral from the Crisis Team. I fully understand Mrs A's concerns that she felt powerless to resolve matters for Mr B, and I appreciate the obvious distress caused to Mr B and his mental health during this time. Whilst I cannot reach a decision on whether Mr B's situation would have been different had the Health Board's failings not occurred, I am satisfied that the uncertainty and distress this has caused both Mrs A and Mr B does amount to an injustice to them. To that limited extent, I consider Mr B's Article 8 rights have been engaged, as a consequence of the failings identified in this report. This resulted in uncertainty and Mr B suffered the indignity of living in a state of isolation, blocking out the world and with limited quality of life, during that time.

41. To reflect the injustice to Mr B arising from the failings identified in this report, I consider financial redress to be appropriate.

Recommendations

42. I **recommend** that the Health Board should within **one** month of the date of this report:

- a) Provide both Mrs A and Mr B, separately, with sincere and fulsome apologies from the Chief Executive for the failures identified in this report
- b) Pay Mrs A £250 in recognition of the poor handling of her complaint and for the additional frustration and disappointment she experienced as a result

- c) Pay Mr B £2000 to reflect the distress and uncertainty caused to him by the failings identified in this report and the impact caused by his right to a family life being compromised.

43. I **recommend** that the Health Board should within **two** months of the date of this report:

- a) Refer this report to the Board and the Health Board's Equalities and Human Rights team to identify how an individual's human rights can be further embedded into its practices and procedures in respect of mental health
- b) Consider the Adviser's suggestion at paragraph 27 of this report and inform me of any further actions it takes/intends to take, as a result
- c) Share this report with the clinicians involved in Mr B's care for them to reflect on the findings
- d) Reassess Mr B's mental health needs and eligibility for secondary mental health care services.

44. I **recommend** that the Health Board should within **six** months of the date of this report:

- a) (i) Audit a sample of patients who have been referred for ASD and mental health assessments to ensure others have not been similarly disadvantaged. If the audit identifies any failures, the Health Board should detail the action taken/it intends to take to address this and provide me with an appropriate action plan and compliance timescale.
- (ii) Audit a sample of mental health assessments from both the first and second CMHTs for consistent application of the criteria for secondary mental health referrals. If the audit identifies any failures, the Health Board should detail the action taken/it intends to take to address this and provide me with an appropriate action plan and compliance timescale.

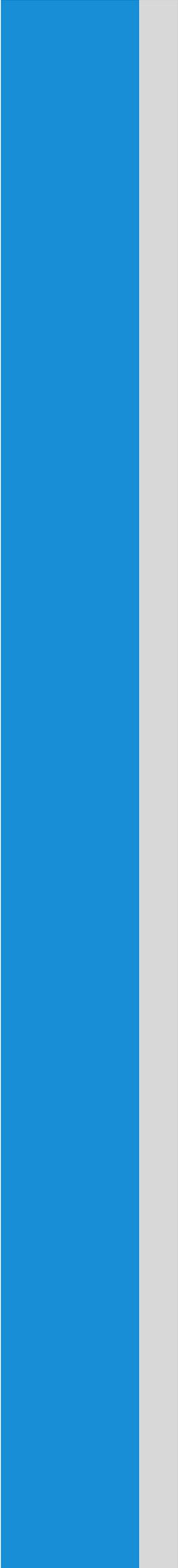
- b) Review its current practice and ensure it follows NICE guidelines to allow patients with dual ASD and mental health needs to be assessed concurrently.

45. I am pleased to note that in commenting on the draft of this report the **Health Board** has agreed to implement these recommendations.



Nick Bennett
Ombudsman

20 September 2018



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