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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint By Ms A against Cardiff and Vale University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201701616

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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 the Solicitor and the aggrieved as Ms A.

Summary

Ms A was detained under the Mental Health Act ("the MHA") in Wales. In October 2015, she moved to a secure hospital ("the Hospital") in England. In March 2016, Ms A was discharged from detention. This meant she was free to leave the Hospital, but she agreed to remain there on a voluntary basis while aftercare[1] and supported accommodation were arranged to support her safe discharge into the community. Ms A remained in the Hospital until February 2017. Throughout, the Health Board remained the responsible body under the legislation to ensure Ms A's aftercare services were provided to her in a timely manner.

Ms A's Solicitor ("the Solicitor") complained about the Health Board's poor care after Ms A's discharge from detention. The Solicitor said that the Health Board failed and/or delayed in providing Ms A with aftercare, appropriate supported accommodation and a referral to the Community Mental Health Team in England ("the CMHT"). In addition, the Solicitor complained that the Health Board failed to provide Ms A with mental health support and a safe environment during the time she remained at the Hospital as a voluntary patient. The Solicitor also complained about the Health Board's poor complaints handling.

My investigation found that the Health Board should have made the necessary aftercare arrangements with the relevant NHS Trust in England before Ms A was discharged from detention. This contributed to the subsequent difficulties and delays.

However, the Health Board did make several referrals to the CMHT to find a solution which would progress Ms A's reintroduction into the community. The CMHT did not accept Ms A's referral until May 2017, and her aftercare was not properly in place until November 2017.
I found that despite the Health Board's attempts to resolve the issue, the main obstacle to progressing Ms A's discharge from the Hospital to local supported accommodation was that the CMHT would not accept the referral from the Health Board until Ms A was registered with a local GP, was discharged from the Hospital, and had a local residential address. Ms A remained an inpatient at the Hospital for almost a year after her discharge from detention, on a locked rehabilitation ward with other patients detained under the MHA.

[1] Under section 117 of the MHA, certain patients discharged from compulsory detention have a right to free aftercare services ("s117 aftercare") funded by the relevant body. Section 117 aftercare is a legal duty which becomes effective when a patient is discharged from hospital and can include healthcare, social care and supported living accommodation.

The Health Board acknowledged Ms A's experience was neither acceptable nor in line with its usual practice but said it could not resolve the issues with the CMHT. From February 2017, it continued to fund a full inpatient service from the Hospital, so Ms A could receive the appropriate care package to enable her to move to the flat she had found.

I upheld Ms A's complaints. I identified a need for cross-border health care guidance. I have shared my report with the Welsh Government for it to review whether action needs to be taken at an all Wales level to reduce the risk of a similar situation arising. Ms A's human rights[2] were also engaged as a result of the failures identified in my report.
I recommended that the Health Board should:

- Provide Ms A with a fulsome and sincere apology from the Chief Executive for the failures identified.

- Refer Ms A's case to its Legal & Redress Team to consider and pay appropriate financial redress in recognition of the distress caused to Ms A by the failures identified in this report and the unnecessary delays which compromised her right to a family life.

- Refer my report to the Board and to 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 care.

- Audit a sample of patients discharged from compulsory detention to somewhere outside the Health Board's area to ensure that others have not been similarly disadvantaged.

- Pay Ms A £500 in recognition of the poor handling of her complaint and the additional unnecessary frustration and disappointment she experienced as a result.

[2] 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 Complaint

1. Ms A's solicitor ("the Solicitor") complained on her behalf about the poor care she received from Cardiff and Vale University Health Board ("the Health Board") after her discharge from detention[3] under the Mental Health Act 1983 ("the MHA"). The Solicitor complained:

- that the Health Board failed and/or delayed in providing Ms A with aftercare, appropriate supported accommodation and referral to a Community Mental Health Team ("CMHT").

- that the Health Board failed to provide mental health support and a safe environment during the time Ms A remained at an independent locked rehabilitation hospital ("the Hospital") as an informal (voluntary) patient as no aftercare provision was in place for her.

- about poor complaints handling, including the delay and the inadequate content of its final complaint response to the Solicitor.

Investigation

2. I obtained comments and copies of relevant documents from the Health Board, including Ms A's records from the Hospital, which I considered in conjunction with the evidence provided by the Solicitor. I also obtained information from the Mental Health NHS Foundation Trust ("the Trust") in England. Finally, I obtained clinical advice from one of my Professional Advisers, Dr S Rao ("the Adviser"), an experienced Consultant Psychiatrist in the NHS.

3. I have had regard to my powers and jurisdiction.[4] My role is to consider complaints from members of the public about poor service/maladministration by a body in Wales listed under my jurisdiction ("Welsh listed body"). This can include complaints about the actions of a body, such as the Hospital, commissioned by a Welsh listed body to provide a service.

[3] Discharge from detention is not the same as discharge from hospital as patients can agree to remain in hospital as an informal patient.
[4] Public Services Ombudsman (Wales) Act 2005.

4. I consider whether the care/service provided by Health Boards, based on information reasonably known at the time of events complained about, falls within acceptable standards. To uphold a complaint, I must be satisfied that an identified failing on a Health Board's part has directly caused an injustice to the complainant or the aggrieved.

5. In this report, I have summarised key events, views, legislation, guidance and the clinical advice received from the Adviser. Whilst I have not included every detail investigated in this report, I am satisfied that nothing of significance has been overlooked.

6. The Solicitor, the Health Board and the Trust were given the opportunity to see and comment on a draft of this report before the final version was issued.

Summary of key legislation, guidance and policies

7. The Mental Health Act 1983 ("the MHA")[5] applies in both England and Wales and provides a legal framework for the compulsory detention and treatment of patients with mental disorders. Treatment in hospital for mental health issues may also take place on an informal basis with the patient's agreement. Patients detained under the MHA are subject to certain requirements should they wish to leave the hospital, but informal patients have the right to leave when they want. Furthermore, patients discharged from detention under section 37 of the MHA have the right to free aftercare services ("s117 aftercare"), funded by the responsible body, which can include healthcare, social care and supported living accommodation. The provision of s117 aftercare is a legal duty which is effective when the patient is discharged from hospital.

8. In Wales, the key national mental health legislation is the Mental Health (Wales) Measure 2010 ("the Measure") and the accompanying Mental Health Code of Practice ("the Code"); England has its own provision and guidance. Mental health providers in Wales are expected to have regard to the Code which reflects the regulations, policy and strategic approach to mental health services in Wales. The Measure places certain statutory duties on health boards in Wales to meet the needs of mentally ill people and provides for the planning, development and delivery of care and treatment to be reviewed as part of a care and treatment plan ("CTP").[6] The Code provides that a CTP

[5] As amended by the Mental Health Act 2007.

[6] Section 18 of the Mental Health (Wales) Measure.

should be comprehensive, person focused, holistic and proportionate to the need and risk of the individual. The main thrust of the Measure is to empower the mental health service user and, wherever possible, to retain his/her independence to promote recovery. The Measure specifies the need for robust processes to be in place for a patient's timely and effective transfer of care between services, and the Code emphasises the importance of good and effective communication between the services involved.

9. In 2011, the Welsh Government issued regulations[7] and statutory guidance[8] about handling complaints about the NHS (commonly referred to as Putting Things Right ("PTR"). PTR provides that a complaint response should be sent within 30 working days of receipt of the complaint. If this cannot be done, the body must inform the complainant of the reason(s) and provide the response within six months. PTR also sets out the information that should be included in a written complaint response.

10. The Human Rights Act 1998 ("the HRA") incorporated the European Convention on Human Rights into UK law. Public authorities, 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 individuals' private and family life, home and correspondence. This is interpreted broadly and can include the right to live independently.

Summary of key events

11. While living in the Health Board's area, Ms A was sectioned (detained) under the MHA.[9] In August **2014**, Ms A was assessed as low in mood and did not engage with planned activities; a significant factor in the latter was thought to be Ms A's lack of contact with her family. The multi-disciplinary team ("the MDT")[10] agreed that Ms A should be moved to a mental health facility closer to her family in a city in England ("the City") which might assist with her therapeutic engagement and could

[7] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
[8] Putting Things Right – Guidance on dealing with concerns about the NHS.
[9] Section 48 of the MHA is used to transfer a person with a mental illness from prison to hospital, and section 49 is a restriction order where the patient cannot leave hospital or be discharged from detention without permission from the Ministry of Justice.
[10] An MDT consists of healthcare professionals with specialised expertise involved in the patient's care.

allow an easier step-down to the community[11] where she wished to live. Ms A's detention was regraded to a section 37 detention (hospital order from the courts without restrictions).

12. In October **2015**, Ms A was transferred to the Hospital in England and the Health Board funded her placement in its locked rehabilitation unit and support for her step-down into the community.

13. The Health Board reviewed Ms A's CTP on 3 February **2016**. The Health Board was disappointed that no clear goals had been identified by the Hospital to assist Ms A's transition into the community and it updated Ms A's CTP accordingly. The Health Board agreed to explore the supported living opportunities for Ms A in the area near her family.

14. Ms A was discharged from section on 31 March. However, Ms A agreed to remain as an informal (voluntary) patient until her s117 aftercare and supported living accommodation were put in place.

15. In April, the Health Board contacted the local Community Mental Health Team ("the CMHT")[12] and requested information about supported living options for Ms A in her area of choice. However, the CMHT refused to share information with the Health Board. The Health Board made referrals for Ms A to the CMHT and there are several documented exchanges between the two, but little progress was made as the Health Board's referrals were refused and Ms A remained an inpatient at the Hospital. The Health Board attempted unsuccessfully to arrange care for Ms A with several care providers in the City area, but Ms A's referral was not accepted because a local CMHT referral was required.

16. The Solicitor emailed the Health Board on 15 July stating that "the only reason [Ms A] remained as an informal patient is that she has nowhere else to go and no aftercare package" in place for her. The Solicitor said that Ms A did not need to live in a hospital setting and that her current situation was detrimental to her mental health. The Health Board responded to the Solicitor on 18 July and assured her that funding of Ms A's aftercare services was agreed in principle. It said the current difficulty was because the CMHT refused to accept Ms A's referral because she had not been discharged from the Hospital, she had no

[11] Step-down is the gradual reintroduction of a formerly detained mental health patient into the community.

[12] CMHTs may provide assessment, care, support, treatment, intervention, advice, guidance and liaison for mental health patients with assessed needs in the community.

residential address in the area, and she was not registered with a local GP. However, the care and domiciliary providers contacted in the City area would not accept the Health Board's referral of Ms A without local CMHT input.

17. The Solicitor formally complained, via email dated 9 August, about Ms A's aftercare and the Health Board's delay, lack of progress with, and lack of communication about, Ms A's transition to the community. The Solicitor said that Ms A's main priority was to be discharged from the Hospital as soon as possible with suitable supported living and s117 aftercare in place for her. The Solicitor said Ms A's current placement as an informal patient had a detrimental impact on her mental health, and that Ms A felt "she is left with no choice but to live amongst some very unwell and unsettled patients".

18. An email dated 10 August from the CMHT to the Solicitor stated the normal process was that if Ms A was a resident at the Hospital and receiving services commissioned by the Welsh team, it would not provide CMHT input until Ms A had been discharged from the Hospital with an address in the community.

19. The Health Board's PTR response dated 5 October stated it did not identify any harm/ 'qualifying liability' in the care provided to Ms A but it did apologise for the delay in Ms A's step-down to the community. Apart from that, the Health Board did not address any of the Solicitor's specific complaints.

20. There were several attempts recorded by the Health Board to find a solution, so Ms A could access the CMHT's services, but these were unsuccessful. Ms A obtained a tenancy in January **2017**, via the City Council, but this was not supported living accommodation.

21. Ms A could not be discharged safely from the Hospital until a suitable home care package was put in place to support her assessed mental health needs. There are records of the Health Board's unsuccessful attempts to progress a suitable care package for Ms A so she could take up her tenancy and live safely. However, whilst certain care providers were identified and showed some initial interest, none would follow through with the arrangements without local CMHT support.

22. There were further delays in arranging a home care package. Ms A, who by then had been an informal patient in the Hospital for almost twelve months, had been attacked (verbally and physically) by other patients. In the interim, the Health Board agreed to fund a full inpatient placement for Ms A to allow the Hospital to provide Ms A's care package at her new tenancy until she could be formally discharged. Ms A moved into her new flat on 27 February 2017 with a care package provided by the Hospital of two calls per day to prompt medication and provide support.

23. The Health Board updated the Solicitor on 31 March and stated that arrangements had been made to meet the CMHT on 25 April to progress Ms A's CMHT referral, and that it had requested two domiciliary care providers to provide costs for the provision of Ms A's care package. On 19 May, the CMHT accepted Ms A's referral and a Care Co-ordinator was allocated to her.

24. Ms A's discharge planning meeting was held on 28 June and the proposed domiciliary care providers agreed to work jointly with staff at the Hospital for a month to provide Ms A with her care package as part of her transition to the community. Additionally, the Health Board gave Ms A the required four week notice of her formal discharge from the Hospital. Subsequently, the Health Board agreed to fund Ms A's s117 aftercare and the relevant Welsh local authority agreed to take over the costs of Ms A's domiciliary care after her full transition to the community was completed.

25. In July, the Hospital informed the Health Board that Ms A's discharge plan was not yet started because the proposed domiciliary care providers had not completed the required risk assessments. The Health Board made several attempts to obtain suitable domiciliary care providers for Ms A, and continued to fund the Hospital with a full inpatient placement for Ms A, so it would continue to provide her with her assessed domiciliary care while she resided in her flat. On 7 November, Ms A moved into new supported accommodation with the appropriate s117 aftercare package in place.

What the Solicitor said on behalf of Ms A

26. The Solicitor said the Health Board delayed Ms A's rehabilitation, delayed Ms A's referral for local CMHT support and failed to provide her with appropriate mental health support after discharge from section in March 2016. The Solicitor said while Ms A was an informal patient, she was effectively unable to leave the Hospital until the Health Board had complied with its statutory duty and put in place her s117 aftercare. It said that, during this time, the Health Board failed to provide Ms A with support and a safe environment, that she was subjected to physical and verbal attacks by other patients and that she witnessed certain incidents during a time she did not require detention. The Solicitor concluded that Ms A's experience had, and continues to have, a significant and detrimental impact on her mental health.

27. The Solicitor said the Health Board's complaints handling was poor and failed to respond to any of the specific concerns raised. This caused added frustration and distress to Ms A. She felt the Health Board would not listen to her and she felt devalued by the Health Board's dismissive response.

What the Health Board said

28. The Health Board said Ms A's s117 aftercare package proposed local CMHT support alongside supported living accommodation. It said it commissioned the services of the Hospital with the express intent of the locality assisting with transition planning to local services and that a senior nurse in the Complex Care and Commissioning Team made initial contact with the CMHT in April 2016 both to progress Ms A's referral to the CMHT and to seek information on suitable supported living options for Ms A close to her family.

29. The Health Board acknowledged that it did not follow its own policy[13] for patients discharged from compulsory detention in Ms A's case. It acknowledged that Ms A's s117 aftercare plan and her referral to the CMHT should have been formulated prior to her discharge from detention hearing on 31 March 2016. In addition, it said patients with a forensic risk history, like Ms A, are usually referred to a local CMHT three to six months prior to their step-down to the community. This would allow for a period of joint working and time to build therapeutic

[13] The Health Board's Joint Policy on section 117 of MHA 1983 between the Health Board and the two relevant local authorities in its area.

relationships between a patient and the local CMHT. The Health Board acknowledged that Ms A was not referred to the CMHT until after her discharge from detention in April 2016.

30. The Health Board said a significant factor in the delay was the difficulty it encountered in accessing local supported living options and local CMHT input for Ms A in the City's area. The Health Board said the Trust and the CMHT would not accept a referral for Ms A until she had a specific residential address and she was registered with a GP in the area. However, as an informal patient Ms A was able to apply for her own accommodation through the local housing services, and she took this route.

31. The Health Board said that although Ms A obtained her own flat in January 2017, to reduce the risk of relapse she required suitable domiciliary carers to call at her property twice a day to oversee and prompt her medication. The Health Board said it approached several local supported living providers from January but encountered the same paradoxical situation as previously; the local supported living providers would not accept a referral from the Health Board, as out of area commissioners, until a local CMHT had accepted Ms A's referral.

32. The Health Board said that in March 2016 the client group at the Hospital changed considerably, which led to several incidents, some targeted at Ms A. The Health Board said the Hospital assured it that detained patients were subject to appropriate levels of supervision which reduced the risk they posed to Ms A. It said it did consider whether to put additional observations in place for Ms A's safety at this time but concluded that this would have resulted in further deprivation of her liberty. The Health Board wished to sincerely apologise to Ms A for the distress caused by her continued hospitalisation and for the incidents she witnessed or was involved with.

33. The Health Board acknowledged that these factors should have been resolved earlier and concluded that Ms A's experience was neither acceptable, nor in line with its usual practice. It wished to offer Ms A its profound and sincere apologies for the delays she experienced in her access to appropriate and timely community support, and the delays experienced in the progress of her recovery to independent living.

34. The Health Board also acknowledged its complaint response did not meet its usual standards, and that it was sorry to hear Ms A felt this experience had created the impression that her concerns were not of importance. The Health Board wished to stress that this was not the case and wished to offer Ms A its apologies.

What the Trust in England said

35. The Trust confirmed that the Health Board had referred Ms A for mental health support in the community and had approached the CMHT. The Trust provided relevant policies,[14] and said it is GP registration that determines which CMHT is allocated to an individual in its area. It said Ms A's discharge address was an independent hospital, and the Health Board could not provide the CMHT with a local residential address or a local GP that Ms A was registered with. The Trust said the CMHT dealt with each of the Health Board's referrals in a timely and appropriate way and it confirmed that the Health Board's referrals for Ms A remained closed until it was able to provide the details requested.

36. The Trust emphasised that the Health Board was responsible for Ms A's statutory s117 aftercare and was ultimately responsible for meeting her assessed needs in the community. The Trust said the delays to Ms A's care package (to supervise her medication at home) related to funding, which was the responsibility of the Health Board.

Professional Advice

37. The Adviser said s117 aftercare is aimed at reducing the likelihood of patient relapse and readmission to a hospital/facility for further treatment for the same disorder. The Adviser said it is usual practice for a discharge plan to be prepared for a detained patient which would be worked towards in anticipation of his/her discharge from detention.

38. The Adviser said the s117 aftercare duty is jointly imposed on the local authority and local health board to provide a free and seamless aftercare service for a patient once discharged from the hospital/facility. The Adviser said the Health Board was statutorily responsible for Ms A's s117 aftercare and there should have been better planning for a robust aftercare service for her.

[14] The Trust policies included its Section 117 Aftercare Policy; Adults of Working Age Inpatient Service description and Standard Operating Procedure; Community Mental Health Area Teams Service Description and Standard Operating Procedure; a Discharge Checklist and its 7-day Follow up Procedure.

39. The Adviser said the main obstacle to the progress of Ms A's discharge from the Hospital to a local supported environment was complex. He said the CMHT would not accept a referral from the Health Board until Ms A was registered with a local GP and discharged from the Hospital and lived at a local residential address. However, the supported living providers would not accept a referral to assess Ms A for placement without prior local CMHT input.

40. The Adviser said that when Ms A obtained a flat in January 2017, the same 'catch 22' argument applied. The CMHT would not accept a referral until Ms A was discharged formally from the Hospital and lived at a local address, but the supported living providers would not accept a referral from the Health Board (as an out of the area commissioner) until Ms A had local CMHT input. As a result, the Adviser said Ms A remained an informal patient from March 2016 until February 2017, although she did not need to be in a hospital setting. The Adviser said it could adversely affect a patient's mental health if they remained in a hospital setting longer than necessary, as in Ms A's case.

41. The Adviser noted that one suggestion made to the Health Board was to discharge Ms A from the Hospital, so she could present as homeless to the local council which would enable her to access their services. The Adviser said, fortunately, the Health Board did not favour this plan due to the risk of Ms A's exploitation, and a relapse in her mental health from possible poor compliance with her medication without supervision.

42. The Adviser said local policies usually clarify transition arrangements and responsibilities for s117 aftercare between services. The Adviser said the above 'catch 22' argument needs to be addressed because it is not uncommon for patients discharged from compulsory detention to move to a different area.

43. The Adviser said he is not aware of any national guidance that addresses such an anomaly but considered that, since CMHT support is necessary to help in a patient's transition as part of a s117 aftercare arrangement, CMHTs should be able to allocate a worker even if a patient's accommodation issue is unresolved.

The Health Board's comments on draft report

44. In response to my draft report, the Health Board highlighted the many efforts it made to progress Ms A's re-integration into the community. It said it was not able to resolve or influence certain factors, such as the CMHT's acceptance of Ms A's referral, as there is no national guidance on the cross-border health care issue identified in the report.

45. The Health Board assured me and Ms A that it would not have taken action to compulsory detain Ms A if she had left the Hospital and said that it made every effort for her to have the appropriate care arrangements in place to secure her safe discharge from the Hospital. The Health Board acknowledged there were delays in these arrangements but highlighted that certain factors were outside its control.

46. The Health Board said Ms A's complaints had been a significant organisational learning curve, not only from her specific case but generally for patients who are placed in the independent sector. It said it had made changes to its CMHT arrangements. Now when patients coming into its area require CMHT input as part of Section 117 aftercare, the patient is not tied to first having a local CMHT accept that referral. It said this also applied to service providers in its area.

Analysis and conclusions

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

48. The Solicitor raised specific complaints about the Health Board's delays and failures in Ms A's s117 aftercare following her discharge from compulsory detention under the MHA. The Health Board had the statutory responsibility to ensure Ms A's s117 aftercare was appropriate and provided in a timely manner. The Health Board's candid and transparent response to my investigation is to be commended, and I was pleased to note that it had identified and acknowledged a number of failings.

49. The Health Board should have put in place an appropriate discharge plan for Ms A before her discharge from section hearing in March 2016. In failing to do so it was on the back foot to start with. In April 2016 the Health Board attempted to progress Ms A's step-down plan towards living in the community. It referred her to the CMHT and looked to source supported living options in the area close to Ms A's family. These proved problematic, and the Health Board faced challenges due to the apparently inflexible and unhelpful stance taken by the Trust and the CMHT. However, the Trust was following its own policies and procedures and ultimately as Ms A was a patient of the Health Board it was responsible for finding a solution to the problems it faced.

50. The Adviser said there is no specific guidance to address the anomaly which occurred here, where the local CMHT would not accept a referral direct from the Health Board without Ms A having a local address. Ms A found herself in a 'catch-22' situation where she could not acquire a local address without support from the CMHT, but without an address the CMHT would not accept her as a client and so would not support her move from the Hospital.

51. Such a situation cannot be an unusual occurrence and it is essential to have a definitive pathway for cross-border mental health care. The focus should be for mental health professionals to strive to develop appropriate and timely mental health services for such vulnerable patients, no matter where in the UK the patient wishes to reside and what part of the UK is responsible to fund the provision.

52. Even when Ms A obtained a private tenancy herself in January 2017, as this was not a supported living facility she could not be formally discharged from the Hospital until the appropriate domiciliary care was in place to manage her medication and prevent a relapse in her mental health. The Health Board accept that the length of time taken to provide Ms A with this domiciliary care to allow her to safely be discharged from the Hospital was unacceptable. This meant Ms A was unable to leave the Hospital for several more weeks until such provision was in place. Despite the Health Board funding the Hospital to assist with Ms A's step-down and reintroduction to the local services, the Hospital does not appear to have actively pursued that. From February 2017, to avoid any further delay in Ms A moving to her flat, the Health Board funded a full inpatient service from the Hospital to ensure Ms A received care and support at home.

53. I find it particularly disheartening that Ms A was significantly let down by the health services at a pivotal time in her mental health recovery. She remained on a locked rehabilitation ward with detained patients when she should have been progressing with her recovery and in establishing her independence. This unacceptable situation continued for almost a year. I **uphold** this complaint.

54. During the extended period that Ms A lived in the Hospital as an informal patient, the Health Board failed to provide her with a safe environment. The Health Board acknowledged that this was unacceptable and that to some extent, Ms A was targeted by other patients during this time and she lived alongside patients detained under the MHA. The Adviser said such circumstances would have had an impact on Ms A and that it is remarkable that her mental and physical health did not deteriorate during this difficult period. I **uphold** this complaint.

55. The Solicitor complained about the Health Board's poor complaints handling. PTR sets out specific actions, timescales and the content of responses that the Health Board should comply with when considering, and responding, to the complaint. The Health Board's complaint response was written in general terms. It lacked depth or proper explanation and failed to respond to the specific complaints raised by the Solicitor. It did not explain the reasons why it considered no qualifying liability arose in its care of Ms A. This was required under PTR and the omission is unacceptable.

56. Whilst the Health Board's response was only a few days over the 30-day PTR timescale, it is unclear why the response took over a month to issue in view of the lack of content. The delay simply added further unnecessary time to the complaints process which left Ms A feeling further frustrated, disappointed and added to her distress about her situation. I can only imagine how such a situation would have caused Ms A to feel and I note that she felt unheard and disempowered despite representation by the Solicitor. This is maladministration which caused injustice to Ms A, and I **uphold** this complaint.

57. The Health Board's decision that no 'harm' was caused to Ms A and as a result there was no 'qualifying liability' is difficult to reconcile with the facts of this case. Whilst the Health Board was candid in its response to me (paragraphs 33 & 34) I am concerned that it did not identify failings itself during its investigation. This could have avoided the need for the Solicitor to bring Ms A's complaint to me. This is the type of poor complaint handling referred to in my thematic report 'Ending Groundhog Day: Lessons from Poor Complaint Handling'.

58. I now turn to Ms A's human rights. My role is to promote the human rights of ordinary people in their dealings with public services in Wales. Ms A was a vulnerable individual and her needs and wishes should have been properly taken into account and she should have been treated with fairness, respect, equality, dignity and autonomy. Where I find evidence of service failure which directly caused injustice to an individual, it is appropriate for me to consider whether the person's human rights have been compromised. Based on all the information provided, I conclude that Ms A's human rights have been substantially impacted by the service failures identified in her care.

59. The Health Board attempted to progress Ms A's transition to the community. It was the responsible body under the legislation to ensure s117 services were provided to Ms A in a timely manner despite the difficulties it faced. Ms A suffered the indignity of remaining in a locked hospital with little option but to remain as a voluntary patient. I can fully understand that Ms A felt powerless at this time. Even when her solicitor made a complaint to the Health Board, Ms A's voice was not heard. I am satisfied that Ms A's Article 8 right to a family life was significantly compromised for many months longer than it should have been. Ms A was unable to fully engage with a family life and the wider community during her time in the Hospital.

60. To reflect the injustice to Ms A identified in this report, I consider financial redress should be considered by the Health Board. Financial redress is recommended to reflect the effects of the failings identified in this report and the injustice to Ms A.

61. In view of the possible systemic failures identified in this report which may affect other people in Wales I have shared a copy of this report with the Welsh Government, so it can review whether action needs to be taken at an 'all Wales' level to resolve any barriers which prevent patients, in receipt of cross-border mental health treatment, receiving timely care and treatment.

Recommendations

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

a) Provide Ms A with a fulsome and sincere apology from the Chief Executive for the failures identified in this report.

b) Pay Ms A £500 in recognition of the poor handling of her complaint and the additional unnecessary frustration and disappointment she experienced as a result.

c) Refer Ms A's case to its Legal & Redress Team to consider the appropriate financial redress in recognition of the failings identified in this report and the unnecessary delays which compromised Ms A's right to a family life. Once a provisional redress figure has been identified the Health Board should provide me with details of the proposed redress for approval so that I can be satisfied that it has taken into consideration all of the failings identified in my report. Once the figure has been confirmed, payment should be made to Ms A within one month.

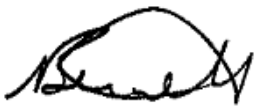
63. I **recommend** that the Health Board should **within six months** of the date of the final report:

d) Refer this report to the Board and to 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 care.

e) Audit a sample of patients discharged from compulsory detention to somewhere outside the Health Board's area to ensure that others have not been similarly disadvantaged. If the audit identifies any failures, the Health Board should detail the action taken to address this and provide me with an appropriate action plan and compliance timescale.

f) Provide me with appropriate documentary evidence to show the above recommendations have been carried out within the above stipulated timescales. Also, to inform me of the outcome of the Health Board's proposed financial redress in paragraph 62 (c) above.

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



Nick Bennett 16 November 2018
Ombudsman

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