

The Ombudsman's Casebook

Issue 29 July 2017

News

Complaint Handling in the Health Sector Seminar

Following our recent thematic report '[Ending Groundhog Day: Lessons in Poor Complaint Handling](#)' we held a seminar for staff in the health sector to share best practice in complaint handling.

The seminar aimed to encourage bodies to use complaints as a learning tool and we hope to see a complaints network established going forward.



Reducing vexatious complaints

Last year the Ombudsman introduced local resolution for county councils to encourage low level complaints to be referred to the Monitoring Officer in the first instance.

Town and community councils have started to adopt this approach and One Voice Wales has published a Model Protocol to encourage and help them to do so.

You can download the model protocol below.

[Model Local Resolution Protocol](#)

Ombudsman elected OA Chair

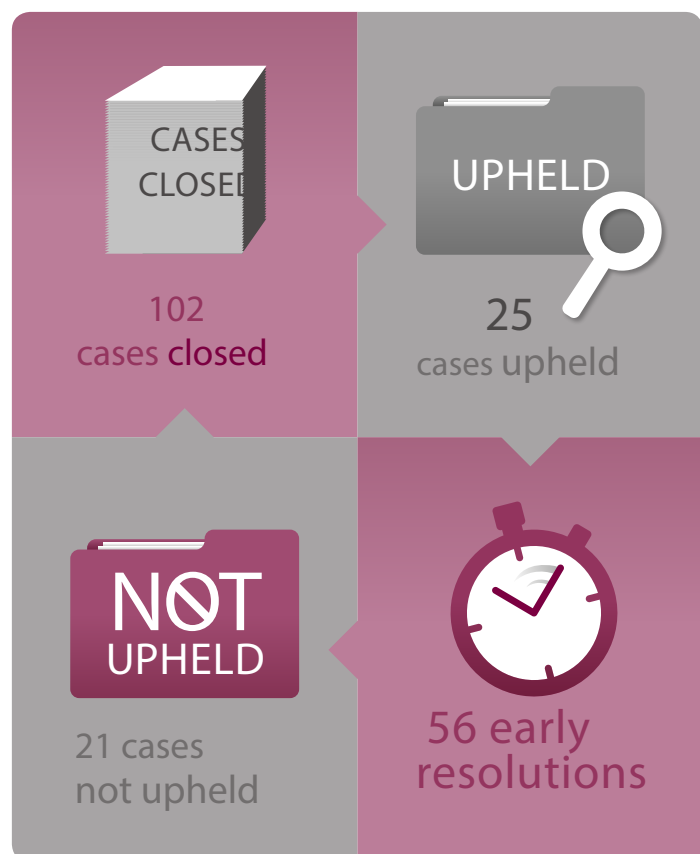
After two years as a member of the Ombudsman Association Executive Committee, Nick Bennett was delighted to be appointed as Chair at the AGM in May.



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Casebook in numbers



This infographic illustrates the cases closed between April and June 2017. It does not include enquiries or complaints deemed premature (where public bodies have not been given the opportunity to resolve a complaint locally) or out of jurisdiction.

Please note the early resolutions category also includes voluntary settlements.

Health

UPHELD

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201600228 – Report issued in April 2017

Mrs A's husband was admitted to Ysbyty Glan Clwyd ("the Hospital") on several occasions between 2 September and 17 December 2014 as he was having seizures. Mrs A complained about the poor care and treatment her husband, Mr A, received while an inpatient. In particular, she complained that there was a catalogue of failures which included Mr A being over-medicated. She also complained about poor communication and complaint handling.

The Ombudsman's investigation concluded that during Mr A's first hospital admission earlier clinical input should have been provided from a clinician whose specialism was epilepsy. The Ombudsman was also concerned that there were periods when there were no clinical entries documenting whether Mr A had been reviewed. The Ombudsman was of the view that this resulted in a failure to assess the frequency of Mr A's seizures and his response to medication and on this basis partly upheld Mrs A's complaint.

In relation to Mrs A's concern that her husband was over-medicated, the Ombudsman found no evidence of this and did not uphold this part of Mrs A's complaint.

In addressing Mrs A's concerns about poor communication, the Ombudsman was of the view that during Mr A's first admission communication with the family was not as effective as it might have been. As a consequence, this caused undue distress and frustration to the family and to that extent he upheld this aspect of Mrs A's complaint.

In relation to Betsi Cadwaladr University Health Board's ("the Health Board") handling of Mrs A's complaint, the Ombudsman was satisfied that the complexity of Mrs A's case meant that some delay in the Health Board providing a response was not unreasonable. He therefore did not uphold this aspect of Mrs A's complaint.

The Ombudsman's recommendations included the Health Board:

- a) apologising to Mr and Mrs A for the shortcomings identified and,
- b) reminding its staff about their professional obligations regarding record keeping.

A dentist in the area of Cardiff and Vale Health Board – Clinical treatment outside hospital Case Number 201602939 – Report issued in April 2017

Mr X complained that his dentist ("the Dentist") failed to X-ray his tooth before extracting it. He said that the wrong tooth was extracted, resulting in unnecessarily prolonged symptoms and a subsequent further extraction.

The Ombudsman found that the poor standard of record keeping on the Dentist's part made it impossible to say whether an X-ray should have been undertaken. Additionally, because of the inadequacy of the Dentist's records, it was not possible to say whether the wrong tooth was initially extracted. The Ombudsman concluded that this uncertainty resulted from the shortcomings in the Dentist's record keeping and constituted an injustice to Mr X.

The Dentist agreed the Ombudsman's recommendations for redress by way of:

- a) a formal letter of apology, and
- b) a payment of £300 in recognition of the uncertainty with which Mr X had been left in respect of his treatment.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number 201506691 – Report issued in April 2017

Ms X complained about the care and treatment her late father, Mr Y received at Ysbyty Glan Clwyd in 2015. Specifically, Ms X said that there had been a delay in carrying out appropriate risk assessments which contributed to Mr Y falling on two occasions in three days and sustaining injuries. Ms X also complained that Mr Y was unnecessarily denied food and fluids from 23-25 April 2015.

The investigation found that there had been a failure to ensure that Mr Y's risk of falling had been minimised and that Betsi Cadwaladr University Health Board's ("the Health Board") failure to update Mr Y's care plans to reflect his mobility needs, falls and injuries placed him at further risk. The investigation also found that the failure to undertake an accurate risk assessment of Mr Y's toilet needs placed him at further risk.

The investigation found that the decision to catheterise Mr Y without discussing the associated risks with his family given Mr Y's pre-existing conditions was of some concern.

Finally the investigation found that, given Mr Y's risk of aspiration, it had been reasonable to place Mr Y on a nil by mouth treatment plan.

It was recommended that the Health Board:

- a) apologise to Mrs Y and her family
- b) pay £250 in recognition of the time and trouble in bringing the complaint to this office
- c) provide the relevant Ward staff with refresher training on the completion of assessments and the management of incidents on the Ward, and
- d) remind relevant clinicians are reminded of the principles of good record keeping.

GPs in the area of Cardiff and Vale University Health Board – Clinical treatment outside hospital

Case Number 201505030 – Report issued in April 2017

Mrs N complained about the care given to her late husband, Mr N, by two GPs in the area of Cardiff and Vale University Health Board ("the GPs"). She reported that these GPs did not complete an internal examination of Mr N. She said that they failed to investigate his symptoms of pain, rectal bleeding and constipation properly as a result. She suggested that Mr N's bowel cancer could have been diagnosed and treated at a much earlier stage if this investigative failing had not occurred.

The Ombudsman found that the GPs, namely the First GP and the Second GP, had not investigated and assessed Mr N's constipation correctly. He also determined that it would probably have been possible to diagnose and treat Mr N's bowel cancer sooner if the GPs' care of him had not been marred by these assessment and investigative failings. He upheld Mrs N's complaint. He recommended that the GPs should:

- a) write to Mrs N to apologise for the failings identified
- b) prepare action plans aimed at preventing a repetition of these failings, and
- c) that the First GP and the Second GP should pay Mrs N £1000 and £500 respectively.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201601466 – Report issued in April 2017

Mrs D complained about the care and treatment her late husband, Mr D received upon his admission to the Emergency Department at the Royal Gwent Hospital ("the Hospital") on 2 February 2015. Her concerns were that the nursing care and medication provided to her husband led to his deterioration. Mrs D was also unhappy that staff at the Hospital did not tell her how ill her husband was or inform the family of his deterioration to help them prepare for his death. Mrs D also complained that there was not a properly completed "Do Not Attempt Cardiopulmonary Pulmonary Resuscitation" ("DNACPR") form within her husband's medical notes. Finally, Mrs D raised concerns regarding the cause of a reported penile trauma on the post mortem report.

The Ombudsman's investigation concluded that the nursing care and medication provided to her late husband was reasonable and appropriate and did not uphold this element of her complaint.

In addressing Mrs D's concerns about poor communication, the Ombudsman acknowledged there were difficulties in communication between medical staff and the family, but an earlier discussion may have better managed the family's expectations and prepared them for the deterioration in Mr D's condition and the outcome. It may also have enabled the attendance of a Catholic priest to read Mr D his Last Rites in accordance with their religion. This element of the complaint was upheld.

In relation to the DNACPR form, the Ombudsman found that even though the form was not completed properly, this did not invalidate the form or the decision, and this aspect was not upheld.

There was a lack of information to consider in reaching a conclusion in respect of Mrs D's concerns regarding a reported penile trauma on the post mortem report of Mr D. The Ombudsman was unable to make a finding on this point.

The Ombudsman's recommendations included Aneurin Bevan University Health Board:

- a) apologising to Mrs D for the failings identified, and
- b) sharing the findings of the report with nursing and clinical staff concerned.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201601572 – Report issued in April 2017

Mr X complained about the care provided to his late mother, Mrs Y, by Betsi Cadwaladr University Health Board ("the Health Board"), during November 2015. In particular, that Mrs Y was not treated on an appropriate ward and that communication with Mrs Y's family was insufficient and inappropriate.

There was no evidence to suggest that Mrs Y was not treated on an appropriate ward. However, earlier consideration should have been given to the need for specialist respiratory input. It was also clear that the level of nursing care provided to Mrs Y fell below an acceptable standard, particularly in relation to her nutrition and hydration.

There was an evident communication issue in this case. However, the Health Board had undertaken reasonable action to resolve this element of the complaint.

In respect of the failures identified, the following recommendations were made:

- a) financial redress in recognition of the time and trouble caused to Mr X in pursuing his complaint, and
- b) provide Mr X and the Ombudsman with an update in relation to the measures taken to resolve Mr X's complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201602959 – Report issued in May 2017

Mrs A complained that there was a delay in the diagnosis of her ectopic pregnancy and that the treatment provided was not appropriate. She was treated conservatively and not offered surgery in the first instance. She then had to undergo surgery in any event. She also complained that the explanations given to her at the time were confusing and that Abertawe Bro Morgannwg University Health Board's ("the Health Board") response to her complaint did not address her concerns properly.

The Ombudsman found that there was some doubt about the initial diagnosis because of an atypical presentation on the initial scan. However, he found that the diagnosis was confirmed after a further scan and was not delayed. He did not uphold this part of the complaint. However, given the size of the mass and the high initial HCG hormone level, he concluded that surgical intervention should have been discussed and offered as a first line treatment on confirmation of the diagnosis, rather than conservative management, in line with national guidance. He upheld this aspect of the complaint. He also expressed concern about the timescales for histology results and the Health Board confirmed that it was taking steps to address resource and staffing levels for this service. The Health Board also accepted that its initial

complaint response to Mrs A should have been better and offered a payment of £250 to Mrs A to reflect this.

Welsh Ambulance Services NHS Trust – Ambulance Services Case Number 201505819 - Report issued in May 2017

Mr Y complained about the treatment given to his partner, Ms T, by the Welsh Ambulance Services NHS Trust ("the Trust"). He told the Ombudsman that the Trust's ambulance crew ("the Crew") did not document that Ms T had neck pain, place her in a neck collar or make hospital staff aware of her possible neck injury. He also said that the Crew and the Trust's call handler failed to accurately record the details of Ms T's seizure.

The Ombudsman identified a complaint handling deficiency and several clinical failings. He partly upheld Mr Y's complaint because he considered that the Crew had potentially placed Ms T at risk of further injury by not completing, and recording the outcome of, a neck injury assessment. He asked the Trust to:

- a) apologise to Ms T and Mr Y for the failings identified within his report, and
- b) share the key clinical points made in that report with all of its paramedics and emergency medical technicians.

The Trust agreed to implement these recommendations.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201604710 - Report issued in May 2017

Mr B complained about the care his late wife, Mrs B, received at Prince Phillip Hospital between 8.35am and 1.40pm on 14 May 2015. He complained that staff failed to carry out adequate observations or to provide his wife with adequate pain relief.

The Ombudsman found that although staff did not formally record details of observations undertaken during that period, no adverse clinical outcome resulted from their absence. The Ombudsman did not uphold this element of the complaint. The Ombudsman did find that there was a lack of continuity in Mrs B's care, which led to ad hoc pain relief being administered, rather than proactively managed. The Ombudsman upheld this aspect of the complaint. The Ombudsman recommended that the Health Board should:

- a) apologise to Mr B
- b) review the adequacy of staff training in end of life care, and
- c) ensure that staff training in this area was up to date.

Betsi Cadwaladr University Health Board and Flintshire County Council - Other Case Numbers 201502879 & 201503954 - Report issued in May 2017

Mr X complained that allegations of inappropriate behaviour by him towards his carers were not put to him to respond to and were not properly investigated. Mr X also complained he had been denied the option of arranging his own carers using Direct Payments and had been left without carers for two years. Finally, Mr X complained that there were disproportionate delays in handling his complaint.

The Ombudsman found that the allegations had not been handled or investigated appropriately. He also found that Mr X's request for Direct Payments had not been appropriately considered. The Ombudsman concluded that Mr X had been avoidably left without care input for two years and that Betsi Cadwaladr University Health Board ("the Health Board") and Flintshire County Council ("the Council") had failed to make an appropriate offer of care. Finally, he found that complaint handling had been poor and disproportionately delayed.

The Ombudsman recommended:

- a) procedural changes in relation to the handling of such allegations
- b) a reconsideration of Mr X's needs and how these would be met
- c) apologies should be made, and
- d) that the Health Board and Council should pay Mr X redress in the sum of £2300 and £1450 respectively, in recognition of the shortcomings identified.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number 201602730 - Report issued in May 2017

Mrs X complained that the Health Board had failed to act promptly in diagnosing cancer and a wait and see approach was unsatisfactory and unjustified by the continued symptoms she was displaying. Mrs X also said that a referral to a specialist cancer centre should have been made sooner.

The investigation found that although the outcome of Mrs X's pancreatic cancer would have remained the same, there were shortcomings in the Health Board's care of Mrs X, which included a CT scan being taken inappropriately, a delay in referring Mrs X to a specialist cancer centre and a delay in responding to Mrs X's GP referral.

The Ombudsman partly upheld the complaint and made recommendations to the Health Board for:

- a) an apology
- b) appropriate redress, and
- c) to produce an operational policy for pancreatic and hepatobiliary tumours, ratified by its specialist cancer centre.

The Health Board accepted the recommendations and the Ombudsman was pleased to note the prompt action it was taking to address its operational policy.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201602038 - Report issued in May 2017

Mrs F complained about her treatment for Atrial Fibrillation, saying Cardiff and Vale University Health Board ("the Health Board") failed to consider her risk factors for a cardiac procedure, which led to her warfarin (blood thinning medication) being stopped inappropriately. Mrs F said that she experienced a post operative blood clot and delayed seeking medical treatment when she fell ill. Mrs F said that the lack of warning resulted in damage to her lung.

The investigation found that Mrs F's risk factors for stopping warfarin were appropriately considered and it was reasonable to stop her warfarin. The Ombudsman was satisfied that the subsequent blood clot was not as a result of any shortcoming by the Health Board. The Ombudsman did not uphold these complaints.

While discussions about the risks of the procedure, including blood clot, had taken place with Mrs F, the Ombudsman could not safely conclude that the risks had been made sufficiently clear during the consent process. The Ombudsman upheld this complaint

The Ombudsman made recommendations in respect of:

- a) clinicians' discussions of risk during the consent process
- b) nominal financial redress, and,
- c) a review of internal policy.

Aneurin Bevan University Health Board - Other

Case Number 201601828 - Report issued in May 2017

Mrs A complained about the care and treatment provided to her son, Mr A, by the Community Mental Health Team ("CMHT"). She said that Aneurin Bevan University Health Board ("the Health Board") had done very little to address her son's mental health issues and left him in a vulnerable position. She also complained about the Health Board's poor complaint handling.

The Ombudsman's investigation considered the care provided to Mr A was broadly reasonable and appropriate and therefore did not uphold this aspect of Mrs A's complaint.

In relation to Mrs A's concerns about the delay in responding to her complaint, the Health Board in responding to the Ombudsman acknowledged that it had failed to respond to Mrs A in a timely manner and apologised for this. In recognition of its failings, the Health Board offered Mrs B a payment of £250.

In addition, the Health Board offered assurance that improved processes had been put in place to ensure better monitoring of complaints. The Ombudsman upheld Mrs A's complaint and recommended that the Health Board should:

- a) apologise to Mrs A for the poor complaint handling, and
- b) pay her the sum of £250 previously offered in recognition of the distress caused by this.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201601674 - Report issued in May 2017

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to identify and treat Mr X's pneumonia infection and scan him prior to his discharge home ("the first admission"). Mrs X complained that Mr X's discharge home on 26 March 2015 was inappropriate and the Health Board ignored her concerns about him prior to his discharge. Mrs X also complained that as a direct result of these failures, Mr X's condition significantly deteriorated and he was re-admitted to hospital in the early hours of 27 March 2015 ("the second admission"). Mr X died later that morning.

The investigation found, and the Health Board acknowledged, that it failed to identify and treat Mr X's infection. It was not possible to determine whether Mr X's sad outcome might have been different had he received antibiotics, but the continued uncertainty to Mrs X was an ongoing injustice to her, and to that extent this issue was upheld.

Mrs X's concerns about Mr X's condition at his first admission resulted in his further medical review prior to his discharge home. However, the investigation found Mr X's discharge home inappropriate due to the available evidence of his infection. This issue was upheld to the extent of the distress caused to Mrs X by the events that followed Mr X's discharge, and her continued uncertainty that Mr X's outcome might have been different had he remained in hospital. It was found that Mr X's care during his second admission was appropriate.

Recommendations were made, and accepted by the Health Board, which included:

- a) an apology
- b) financial redress, and
- c) other appropriate actions to address the failures identified in the report.

Cardiff and Vale University Health Board and Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201507143 & 201507144 - Report issued in May 2017

Mrs A complained against Abertawe Bro Morgannwg University Health Board ("ABM") and Cardiff and Vale University Health Board ("C&V") regarding Ms B's cannula care and resulting arm infection, her transfer between Health Boards, and the delay in her diagnosis and treatment.

The investigation found the clinical care provided to identify and diagnose Ms B's condition was reasonable, timely and within acceptable clinical practice. This issue was not upheld.

Ms B's transfer between Health Boards lacked documentation but it was clear ABM failed to follow accepted

practice. That said, no clinical harm was identified. This issue was upheld to the limited extent of the distress caused to Mrs A and Ms B by the events around the transfer.

Poor record keeping and lack of documentation made it impossible to determine whether the required standards of cannula care were met. Further, the poor condition of Ms B's arm on arrival at C&V made it impossible to determine, with any certainty, when or whether poor cannula care contributed to the development of Ms B's blood clot and subsequent nerve damage. This issue was upheld against both Health Boards.

Recommendations were made, and accepted by both Health Boards, which include:

- a) an apology
- b) financial redress, and
- c) other appropriate actions to address the failures identified in the report.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201603178 - Report issued in May 2017

Miss Y complained that her mother Mrs X, had an unsuccessful attempt to perform a nasal endoscopy (nasendoscopy) and a request for a CT scan of her mother's face was not undertaken as the Radiology department had not received it. Miss Y said that this delay led to her mother's cancerous facial lump not being diagnosed or treated sooner.

The Ombudsman found that there was no criticism of Mrs X's nasendoscopy. The Ombudsman found that Mrs X was initially correctly diagnosed and treated for dacryocystitis (infection of the tear duct). Further investigation led to a diagnosis of B-Cell Lymphoma, a very rare condition that mimicked dacryocystitis. Mrs X was referred for urgent cancer treatment within two days of being diagnosed; the Ombudsman found there had not been an unacceptable delay between the diagnosis and treatment of cancer. The Ombudsman did not uphold these aspects of the complaint.

The Ombudsman found that Mrs X's initial request for a CT scan had not been received by the Radiology Department and upheld this aspect of the complaint. In view of the Health Board's intention to introduce a system for electronic request for CT scans no recommendation was made. The Ombudsman recommended that Abertawe Bro Morgannwg University Health Board apologised to Miss Y that this request had not been received.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201601369 – Report issued in June 2017

Mrs X complained that there was a delay in diagnosing and treating her father's (Mr Y) condition (pneumonia and sepsis) which resulted in him having a reduced chance of surviving his illness. Mrs X complained that she was not advised to visit her father before he sadly died, thereby denying her the opportunity of being with him when he died. Mrs X was also aggrieved that the Health Board's complaint handling was inadequate because of delays in responding to her concerns and by failing to arrange a meeting with its staff to discuss those concerns.

The investigation found that there had been a delay in initiating treatment because Mr Y had to wait in an ambulance for three hours before he was brought in to the Hospital. There was also a delay in providing Mr Y with a diuretic shortly before his sad death. Both of these delays may have affected the outcome for the patient. The investigation also found that there was a failure to undertake observations which detrimentally affected the likelihood of identifying Mr Y's deterioration and of staff being in a position to let Mrs X know of that deterioration sooner. Finally, the investigation found that there had been an unacceptable delay in responding to Mrs X's concern and a failure on the part of Betsi Cadwaladr Health Board ("the Health Board") to arrange the meeting it had offered her. The three heads of complaint were therefore upheld.

To remedy the failings found, the Health Board agreed to:

- a) apologise to Mrs X
- b) make a payment to her of £1000 for the distress caused by the uncertainty as to whether more timely treatment might have affected the outcome for Mr Y
- c) arrange an audit on the relevant ward in respect of observations and escalation of care; and
- d) consider revising the wording of its complaint response letters to better manage the expectations of complainants.

Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board - Other Case Number 201602125 & 201603085 - Report issued in June 2017

Miss X complained that her sister, Miss Y, did not receive appropriate Mental Health support from Abertawe Bro Morgannwg University Health Board ("the First Health Board") and Hywel Dda University Health Board ("the Second Health Board") between 2010 and her death in 2015. Miss X believed that, had appropriate Mental Health support been provided by both Health Boards, Miss Y's death would have been prevented.

The investigation found that, overall, the care Miss Y received from both Health Boards was reasonable. However, two instances were highlighted where the care provided to Miss Y could have been better. That said it was impossible to determine whether these instances impacted upon future events.

The complaint was partly upheld and the Ombudsman recommended that both Health Boards should reflect upon the incidents highlighted in this case.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201602943 - Report issued in June 2017

Ms A complained to the Ombudsman about the manner in which Cwm Taf University Health Board ("the Health Board") had investigated how her baby daughter (known as "B") had suffered bruising whilst being cared for in one of its special care baby units. Ms A was also concerned about the manner in which the Health Board had dealt with her concerns about the investigation into the circumstances by which her daughter suffered the bruising.

The Ombudsman found that the Health Board's investigation into the circumstances of B experiencing bruising was reasonable, and that the likely explanation of accidental bruising was in keeping with the view of external agencies. The Ombudsman did find however that there had been a delay in the Health Board explaining its investigation findings to Ms A and for that reason the complaint was partly upheld.

The Ombudsman recommended that the Health Board:

- a) apologise to Ms A; and
- b) provide her with an explanation why it had not provided her with an account of their investigation findings sooner.

Aneurin Bevan University Health Board – Clinical treatment outside hospital Case Number 201502624 – Report issued in June 2017

Mrs A complained about the care given to her late husband, Mr A, by Aneurin Bevan University Health Board ("the Health Board"). Her complaint concerned the Health Board's Nurse Led Heart Failure Service ("the Heart Failure Service"), an overall review, palliative care and a discharge from hospital.

The Ombudsman did not uphold the discharge part of Mrs A's complaint. He partly upheld the Heart Failure Service element of it. He upheld its overall review and palliative care aspects. He determined that the Health Board failed to identify and address Mr A's palliative care needs at the earliest opportunity. He found that it did not arrange for Mr A to be reviewed in response to a review request. He concluded that it did not give Mr and Mrs A enough written information about the Heart Failure Service and that it took too long to involve that resource in Mr A's care. He recommended that the Health Board should:

- a) apologise to Mrs A for the failings identified; and
- b) introduce a mechanism which enables its heart failure clinicians to systematically and proactively identify any patients who may require palliative care.

The Health Board agreed to implement these recommendations.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201602664 – Report issued in June 2017

Mr X complained about the management of his late mother's liver disease during stays at two of Aneurin Bevan University Health Board's ("the Health Board") hospitals during May and June 2015, including discharge arrangements following the first stay. Mrs Y, who was waiting to undergo an assessment for a liver transplant at a hospital in England, died on 12 June. Mr X also said that Mrs Y had been given incorrect medication on a previous admission and complained about restrictions which were imposed on the family's contact with Mrs Y's body following her death.

The Ombudsman found that Mr X's mother's care had been appropriate during both hospital admissions. He did, however, uphold that part of the complaint which related to discharge arrangements, in that she

should have been referred for district nursing support when she was discharged. There was no evidence to support Mr X's complaint regarding medication, and the Health Board had followed national and its own guidance for dealing with the bodies of deceased persons with infections. He did not uphold these parts of the complaint.

The Ombudsman recommended that the Health Board apologise to Mr X for failing to refer Mrs Y to the district nursing service, which the Health Board agreed to do.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201604191 - Report issued in June 2017

Mr X complained about the care and treatment that he received during his admission to hospital between 23 September and 28 September 2015. Mr X said that there had been a failure to fully explain the risks associated with the catheterisation process and that when the nurse removed the catheter she caused severe bleeding. Mr X also said that given the presence of phimosis (the inability to retract the foreskin over the head of the penis), the nurse should not have attempted to insert the catheter. Finally, Mr X said that Cardiff and Vale University Health Board's ("the Health Board") response to his complaint was inaccurate.

The investigation found that there had been a failure to fully inform Mr X of the risks associated with catheterisation. Therefore, Mr X was not provided with all of the information necessary to make an informed decision about the procedure.

The investigation found that there was no evidence of Mr X experiencing phimosis when he had the procedure, so it was not a relevant consideration at that time.

Finally, the investigation found evidence of poor record which, not only had an unacceptable impact on the Health Board's investigation of Mr X's complaint, but also on this investigation.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr X
- b) pay him a total of £500 in recognition of the service failure and the time and trouble of bringing his complaint to the Ombudsman, and
- c) provide relevant ward staff with additional training on record keeping and consent for catheterisation.

NOT UPHELD

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201601097 – Report issued in April 2017

Mr X, with the assistance of his Advocate, complained about the care and treatment his wife, Mrs X,

received during her admission to hospital between August and September 2015. In particular, he was concerned that he was:

- misled about why his wife was admitted to hospital and was not kept informed about her treatment
- he was unaware that she was on an End of Life Pathway
- she was not given fluids for extended periods
- she was not given her seizure medication for four days which resulted in her suffering fits and was given morphine when she was not in pain.

The Ombudsman found that there were several documented discussions with the family about Mrs X's treatment. He also found that there was no evidence that Mrs X was on an End of Life Pathway and that her fluid management was reasonable. Although seizure medication was missed on some occasions, this was, on the whole as a result of Mrs X's refusal to take them as opposed to any active decision to withhold medication. While this may have contributed to a series of seizures, this was not as a result of any shortcoming. Finally, the Ombudsman found that the decision to administer morphine on two occasions was reasonable in light of Mrs X's condition. The Ombudsman did not uphold Mr X's complaints.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201600916 – Report issued in April 2017

Mrs A complained about the care and treatment of her late mother, Mrs B, between July and December 2015, which she said led to a delayed cancer diagnosis and meant there were no treatment options available to her. Mrs B sadly died in early 2016.

The Ombudsman found that Mrs B had been suffering from a rare form of cancer, cholangiocarcinoma – a bile duct tumour – which, in its early stages, does not cause symptoms. Appropriate investigations were carried out as Mrs B's symptoms, which were not typical of a cholangiocarcinoma, unfolded. If her symptoms had been more typical the order of the investigations might have been different, and the diagnosis made earlier; however, cholangiocarcinomas are usually advanced and incurable at presentation, so earlier diagnosis would not have altered the outcome. The Ombudsman did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201604881 - Report issued in April 2017

Mrs X complained about the care her husband, Mr X, received at the Princess of Wales Hospital. She complained that his symptoms were inappropriately attributed to a progression in his pre-existing Parkinson's Disease and that alternative causes were not investigated. Mrs X complained that an early CT scan would have identified a subdural haematoma (which was later diagnosed) much sooner.

The Ombudsman found that the initial diagnosis of a progression of Mr X's Parkinson's Disease was appropriate given the presenting symptoms. He concluded that an earlier CT scan was not indicated and that there was no undue delay in diagnosing the subdural haematoma. The Ombudsman did not uphold the complaint.

A GP Practice in the Betsi Cadwaladr University Health Board area – Clinical treatment outside hospital Case Number 201602584 - Report issued in April 2017

Mrs D complained about the care and treatment that her late mother, Mrs M, received when, on the day before she died at home, she was visited by a GP from the Practice. Mrs D complained that the GP who conducted the visit:

- failed to appreciate the seriousness of Mrs M's condition and failed to arrange her admission to hospital
- failed to inform Mrs D of her mother's illness and failed to arrange any follow-up care for Mrs M. Mrs D also complained that, in asking questions about these events, Practice personnel had been discourteous to her.

The Ombudsman, guided by his GP Clinical Adviser, did not uphold any of Mrs D's complaints. The Ombudsman determined that Mrs M's condition did not warrant her admission to hospital and that the GP was obliged to respect her expressly stated wish that her daughter should not be notified of her illness.

The Ombudsman was also satisfied that Mrs M's condition did not warrant referral to the District Nursing Service as the GP had taken steps to ensure that Mrs M was able to obtain assistance (either directly or via her neighbours) if her condition deteriorated. The Ombudsman was unable to identify any evidence that personnel at the Practice had been discourteous in their interactions with Mrs D. Finally, the Ombudsman determined that there was no direct link between Mrs M's illness and the cause of her death.

A GP practice in the area of Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case Number 201606074 – Report issued in June 2017

Mr A complained on behalf of his wife, Mrs B that the Practice had failed to adequately diagnose an illness. She was admitted to hospital five days later and needed high dependency care. Mr A felt that if the Practice had properly examined Mrs B, she would have been diagnosed earlier and may not have become quite so ill.

The investigation found that the diagnosis made was reasonable based upon Mrs B's presentation and appropriate advice was given, of what action should be taken should Mrs B's condition deteriorate. There was a discrepancy between the complainant's recollection of events and those recorded by the Practice.

The investigation found that, in either version of the events it was unlikely that the care given would have changed. The complaint was not upheld.

A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital Case Number 201502625 – Report issued in June 2017

Mrs A complained about the care given to her late husband, Mr A, by a GP Practice in the area of Aneurin Bevan University Health Board ("the Practice"). Her complaint raised issues related to a referral to Aneurin Bevan University Health Board's Cardiology Team, community care, a prescription review, palliative care and a home visit.

The Ombudsman found that the Practice's management of Mr A's care was reasonable. He did not uphold

Mrs A's complaint.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board - Other Case Number 201700246 – Report issued in June 2017

Mr X complained that after being prescribed a course of 100mg Idelalisib tablets by a Consultant Haematologist, the pharmacy mistakenly issued him with 150mg tablets instead. After taking the 150mg tablets (without knowing), for two days, Mr X noticed a change in his intestinal function and was advised by the Consultant to stop taking the tablets.

Betsi Cadwaladr University Health Board ("the Health Board") considered Mr X's complaint and identified a breach in the duty of care because of the dispensing error and apologised for this. However, the investigation did not establish that harm had been caused on this occasion. It stated that diarrhoea is a recognised side effect associated with Idelalisib treatment, and that the dosage error did not attribute to the side effects Mr X experienced.

The Ombudsman obtained advice from one his Clinical Advisers who stated that he did not believe that the extra 50mg tablet was the cause of your sudden onset of diarrhoea. The Adviser was of the opinion that it was likely Mr X would have developed Idelalisib-related diarrhoea even if he had continued on the 100mg tablets.

Although the Ombudsman decided that Mr X's complaint should not be investigated, the Health Board agreed to undertake the following in settlement of Mr X's complaint

- Provide Mr X with a payment of £50 in recognition of the distress this incident caused

All Pharmacy staff also received instruction to check all dispensing medication to ensure it correctly corresponds to the prescribing doctors' instructions.

A GP Practice in the area of Betsi Cadwaladr University Health Board– De-Registration Case Number 201700545 – Report issued in June 2017

Mrs H complained that the GP Practice ("the Surgery") delisted her from its patient list unfairly and without warning. Mrs H had made comments on Facebook, and in its complaint response the Surgery said that her comments were deemed to be offensive and warranted removal from the patient list.

The Ombudsman was not persuaded that Mrs H's comments, in themselves, were abusive or malicious, although he accepted that the Surgery felt that the doctor/patient relationship had irrevocably broken down. He found that the Surgery had failed to notify Mrs H of the reasons for its decision to remove her from its patient list, and that it may have been reasonably practicable for a warning to have been issued. The Ombudsman determined that this amounted to maladministration.

The Surgery agreed to undertake the following actions, within six weeks of the Ombudsman's notification, in settlement of the complaint:

- a) Apologise for not notifying Mrs H of the reasons that she was removed from the practice list

- b) Explain the reason/s why it was considered not reasonably practicable to issue a warning letter in this instance
- c) Offer £75 redress for failing to ensure that Mrs H was informed of the reason for its decision to remove her from the practice list; and
- d) Provide a commitment to share the outcome with all the relevant Surgery parties, with a view to not repeating the failures identified.

Cardiff and Vale University Health Board - Appointments/admissions/discharge and transfer procedures Case Number 201700810 – Report issued in June 2017

Ms C complained about the care and treatment she received from Cardiff and Vale University Health Board. (the Health Board") She said that three days after emergency surgery in October 2016, to remove a benign meningioma, she was discharged while suffering with salmonella. There was no further follow up, and despite taking antibiotics, four weeks after surgery Ms C suffered a skull asymmetry and had to undergo a craniectomy. Ms C also said that she was not informed of the full nature and scale of the procedure or prepared for the impact on her appearance, after the operation. After a further two and a half weeks Ms C was discharged from hospital and advised that she required a titanium plate cranioplasty but no date for surgery has been forthcoming.

The Ombudsman found that, whilst a meeting had been arranged to discuss Ms C's concerns, and it appeared that changes had been made as a result of her case, no formal complaint response had been issued, in line with Putting Things Right (PTR).

The Health Board agreed to undertake the following actions, within six weeks of the Ombudsman's decision, in settlement of the complaint:

- a) Provide a formal response to all points of complaint identified, in line with PTR
- b) Clarify and explain whether Ms C's case has been identified as "urgent" or "routine" as well as any relevant applicable guidelines and timescales for treatment; and
- c) Apologise for the failures in complaint handling and offer financial redress of £50 for Ms C's time and trouble.

Cardiff and Vale University Health Board - Other Case Number 201701596 – Report issued in June 2017

Mr X complained on behalf of his family that his late mother, Mrs Y, had sustained an injury at a Cardiff and Vale University Health Board ("the Health Board") mortuary. Mr X also disputed the Health Board's account of the extent of Mrs Y's injury.

The Ombudsman found that the Health Board had reported the incident internally and had self reported to the Human Tissue Authority, which licences the mortuary. It had identified the cause of the injury and identified two action points which it had undertaken. The Health Board had also apologised to the family

for the distress caused by the injury.

The Ombudsman was concerned about the family's dispute as to the Health Board's description of the injury Mrs Y had sustained. Therefore, the Health Board agreed to complete the following actions by 24 July 2017 in settlement of the complaint:

- a) Write to Mr X to clarify the extent of the injury caused to Mrs Y
- b) Apologise for any confusion and distress caused by its description of the injury.

A GP Practice in the area of Hywel Dda University Health Board Case Number 201701274 – Report issued in June 2017

Ms H complained that she was removed from a GP Practice ("the Surgery") but had done nothing wrong. Ms H said that she spoke to the Practice Manager, but was not satisfied and so wrote to the Surgery to raise a formal complaint. When she did not receive a response, Ms H wrote to Hywel Dda University Health Board ("the Health Board"), but still did not receive a response.

The Ombudsman found that there may have been some confusion as to whether the Health Board or the Surgery should have dealt with the concerns, which led to a failure to acknowledge or address the complaint.

The Health Board agreed to undertake the following actions within six weeks of the date of the Ombudsman's decision, in settlement of the complaint:

- a) Apologise to Ms H for her not receiving a response to her letters, and provide an explanation for the complaint handling failures identified
- b) Offer £50 financial redress for Ms H's time and trouble in pursuing the complaint; and
- c) Consider the complaint to determine the sequence of events, address the reason that Ms H was delisted, and provide a full response.

Welsh Ambulance Services NHS Trust - Ambulance Services Case Number 201700834 – Report issued in June 2017

Mr X complained that a First Responder, attending to his late grandmother after a 999 call, failed to listen to him and his family regarding the symptoms and concerns. He complained that the First Responder forced his grandmother into the back of her vehicle despite the family advising that her legs prevented her from getting into the back of cars.

Mr X was concerned that the First Responder was incorrect in her findings that his grandmother's chest was clear as she passed away from Bronchial Pneumonia.

Upon reviewing the information available to him the Ombudsman was concerned about the quantity of information relayed to Mr X as a result of an investigation.

Whilst some failings were identified by the Trust and it apologised, the concern about the chest examination was not addressed and neither did it explain the lessons that have been learned.

Furthermore, a discrepancy between the investigation report and the response letter to Mr X was identified regarding whether supplementary oxygen was administered.

The Trust has therefore agreed to undertake the following actions:

- a) Review the findings of the chest examination and subsequent actions of the First Responder
- b) Address the circumstances in which Mr X's grandmother was moved from the car and back into the house; and
- c) Explain what and how lessons have been learned.

Hywel Dda University Health Board & Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201606556 & 201700278 – Report issued in June 2017

Mrs S complained about the care and treatment her son received when he attended Glangwili Hospital and University Hospital of Wales in August 2015 due to sudden and severe loss of vision. In particular she was unhappy that both Health Boards had failed to diagnose her son with Leber's Hereditary Optical Neuropathy.

At the beginning of the investigation, Hywel Dda University Health Board informed the Ombudsman that it was still dealing with Mrs S's complaint and it was seeking to instruct an independent expert to examine the overall care of Mrs S's son and provide a written report.

After further discussions, the Ombudsman reached a settlement on the basis that an independent report would be commissioned on behalf of both Health Boards to address Mrs S's concerns.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201607275 – Report issued in June 2017

Mr X complained about his mother's eye treatment following a referral to Cardiff and Vale University Health Board ("the Health Board") as a result of cataract surgery complications at another Health Board. Mr X said that his mother's treatment at the Health Board was inappropriate and that her eye sight deteriorated.

In April 2016 Mr X complained to the other Health Board about the concerns he had regarding his mother's treatment at both Health Boards. Despite pursuing his complaint with the other Health Board Mr X did not receive the Health Board's response.

During the course of the investigation, the Health Board proposed a settlement which the Ombudsman considered reasonable to settle the complaint. The Health Board agreed to undertake the following action:

- a) Formally respond to Mr X's specific concerns about the care his mother received following her transfer to the Health Board.
- b) Apologise to Mr X for the breakdown in communication between both Health Boards in responding to his complaint.
- c) Pay him £250 for the time and trouble he experienced in pursuing the complaint and having to contact the Ombudsman's office due to a lack of response.

The Ombudsman was pleased to note the action that the Health Board had taken to settle the complaint.

Betsi Cadwaladr University Health Board - Other Case Number 201607472 – Report issued in June 2017

Mrs X complained that her mother and her late father, Mr Y, had not received an adequate level of nursing support from Mr Y's designated MacMillan Nurse during his illness from May – November 2015.

Mrs X also expressed concerns about how the investigation by Betsi Cadwaladr University Health Board ("the Health Board") into these concerns had been conducted. The Health Board agreed that within one month it would:

- a) arrange for Mrs X to meet the relevant staff discuss her outstanding concerns about the standard of nursing support her parents received during 2015 and how the investigation into her complaint was conducted.

Mrs X agreed with this approach and the Ombudsman decided that this was reasonable action which would resolve this element of her complaint

Hywel Dda University Health Board - Clinical treatment in hospital Case Number 201607263 - Report issued in June 2017

Ms A complained about the care and treatment her mother had been provided, which included concerns that a fracture had not been identified following an x-ray and also that protocol was not followed after her mother had fallen in hospital. Furthermore, Ms A complained that her Mother had been unsafely discharged and that Hywel Dda University Health Board ("the Health Board") had not fully considered the impact of the standard of care provided to her mother. Ms A also complained that she had not received a response to her complaint letter.

The Ombudsman considered there to be failings in respect of the care and treatment provided to Ms A's mother and in the Health Board's complaint handling process, which could be resolved by actions on the part of the Health Board.

It agreed, within one month of the date of this decision to:

- a) Provide a written apology to the complainant which would taken into account the complaints handling failures and in recognition that the treatment and care provided was below a reasonable standard.

It agreed, within two months of the date of this decision to:

- b) Review the procedures radiologists use to report abnormal x-rays requested by A & E and procedures for recalling patients
- c) Ensure staff in A & E and the nursing teams are aware of the importance of good record keeping.
- d) Consider reviewing its discharge procedure
- e) Consider training for junior doctors in A & E, in assessments following a fall where an x-ray appears normal but there are other clinical factors which indicate a higher risk of fracture
- f) Provide further information to evidence how the falls protocol has been communicated to staff.

Hywel Dda University Health Board – Clinical treatment in hospital
Case Number 201607131 - Report issued in April 2017

Mr X complained that Hywel Dda University Health Board (“the Health Board”) failed from the outset to provide the urgent attention to his daughter’s eye condition that was required. The lack of immediate attention resulted in his daughter almost losing sight in one eye, with greatly reduced vision in the other.

The Health Board agreed to undertake the following in settlement of Mr X’s complaint:

- a) Pay Mr X £200 for the delayed complaint handling and the additional time, trouble and distress the matter has caused
- b) Commit to issuing a full PTR response to the original complaint
- c) Commit to explaining why the first response was so inaccurate
- d) Agree to expedite the PTR response and update Mr X accordingly.

Hywel Dda University Health Board – Clinical treatment in hospital
Case Number 201607589 - Report issued in April 2017

Mr X complained to Hywel Dda University Health Board (“the Health Board”) in June 2016 in relation to an incident in Derwen Ward, Glangwili Hospital. Mr X more recently contacted the Ombudsman as to date; he had not received a response from the Health Board.

The Health Board agreed to undertake the following in settlement of Mr X’s complaint:

- provide Mr X with an apology and explanation for the delay in responding to his complaint.
- provide Mr X with a payment of £250 in recognition of the delay

A GP Practice in the area of Cardiff & Vale University Health Board – Clinical treatment outside hospital Case Number 201607719 - Report issued in April 2017

Mr X complained that, following his letter of complaint to Grange Medical Practice (“the Practice”), he was subsequently delisted. Mr X also complained that the Practice had not responded to the concerns raised about prescriptions and staff behaviour in his letter.

The Ombudsman found that Mr X was delisted by the Practice in line with The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004.

Having reviewed the Practice’s complaint responses, the Ombudsman considered that it had failed to respond to Mr X’s concerns.

In settlement of the complaint, the Practice agreed to:

- a) apologise to Mr X for failing to respond to his concerns
- b) respond to Mr X’s recent concerns regarding prescriptions and the behaviour of Practice staff
- c) clarify and explain further its reasoning for delisting Mr X.

Betsi Cadwaladr University Health Board - Other Case Number 201607266 - Report issued in April 2017

Ms X complained that Betsi Cadwaladr University Health Board (“the Health Board”) failed to address her concerns that, whilst her mother was attending an appointment at the hospital, she overheard the Consultant shout at a member of staff as she was booked into the wrong clinic. Ms X’s mother was ashamed to be a patient on that day and found herself so upset by the experience that she refuses to return to the hospital. Ms X complained that the Health Board’s response to her complaint made no mention of the Consultant’s behaviour and concentrated on the member of staff who arranged the appointment.

The Ombudsman found some failings on the part of the Health Board as it did not address the true account of Ms X’s complaint. It has therefore agreed to reconsider the complaint focusing solely on the Consultant’s behaviour and to write to Ms X apologising for the oversight and offer a redress payment for the time and trouble in making the complaint and in recognition that a further investigation will now take place.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201605887 – Report issued in April 2016

Mrs X complained that that Cardiff and Vale University Health Board (“the Health”) had not undertaken a full investigation of her concerns about the treatment of her sister, Mrs Y. It appeared that the Health Board was concerned that Mrs Y did not share the views of Mrs X. However, it did not appear that the Health Board had taken the necessary steps to establish that Mrs X was acting on behalf of Mrs Y.

The Ombudsman asked the Health Board to provide a consent form to the complainant, Mrs X, for completion and, on receipt of the consent form, consider the complaint using the Putting Things Right

Regulations. The Health Board agreed therefore the Ombudsman considered the matter settled.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital

Case Number 201506925 - Report issued in May 2017

Mrs A complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to treat her chronic diverticulitis appropriately after she had been admitted to Glan Clwyd Hospital ("the First Hospital"), on three separate occasions, during a five-week period. Mrs A had been complaining of abdominal pain when each of these admissions took place.

The Ombudsman found that the Health Board's management of Mrs A's diverticulitis, after her admissions to the First Hospital, was clinically appropriate. He took into account, when reaching that view, the improvement in Mrs A's symptoms during these admissions, the accepted rationale for initially delaying particular investigations, the risks associated with emergency surgery for diverticulitis and the general effectiveness of conservative treatment for that condition. He did not uphold Mrs A's complaint.

Cwm Taf University Health Board – Complaint not upheld

Case Number 201602117 - Report issued in May 2017

Mrs A complained that fluid overload caused or contributed to her subsequently diagnosed cardiac condition and caused deterioration in her renal function. She also raised concerns that, following a scan on 19 June 2013, which showed her gallbladder as normal, further investigations should have been conducted to establish the cause of her pain.

The Ombudsman found that it was difficult to determine whether the level of IV fluids given to Mrs A was unreasonable due to the inadequacy of the recording of fluid intake/output. Whilst this was clearly unacceptable, there was no evidence to suggest that the lack of recording or Cwm Taf University Health Board's ("the Health Board") admission of a degree of fluid overload caused or contributed to Mrs A's subsequently diagnosed cardiac condition or caused the deterioration in her renal function. The Ombudsman was not persuaded that the Health Board failed to provide Mrs A with a reasonable standard of care or treatment by not conducting further investigations following her scan. The complaints were not upheld.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201602730 - Report issued in May 2017

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to act promptly in diagnosing cancer and a wait and see approach was unsatisfactory and unjustified by the continued symptoms she was displaying. Mrs X also said that a referral to a specialist cancer centre should have been made sooner.

The investigation found that although the outcome of Mrs X's pancreatic cancer would have remained the same, there were shortcomings in the Health Board's care of Mrs X, which included a CT scan being taken inappropriately, a delay in referring Mrs X to a specialist cancer centre and a delay in responding to Mrs X's GP referral.

The Ombudsman partly upheld the complaint and made recommendations for an apology, appropriate redress, and for the Health Board to produce an operational policy for pancreatic and hepatobiliary

tumours, ratified by its specialist cancer centre.

The Health Board accepted the recommendations and the Ombudsman was pleased to note the prompt action it was taking to address its operational policy.

A GP Practice in the area of Abertawe Bro Morgannwg University Health Board – Deregistration Case Number 201601692 - Report issued in May 2017

Mrs A complained about the decision of a GP Practice ("the Practice"), to remove her adult son, Mr A, from the Practice list. She believed that the Practice failed to take into account her son's disabilities, and should have communicated better with her about the matter. She was also concerned that the response to her complaint from the Practice contained inaccurate and irrelevant information.

The Ombudsman found that Practice was entitled to take the decision it had on the grounds that there had been an irrevocable breakdown in the doctor-patient relationship. The Ombudsman was satisfied that the Practice had taken Mr A's health conditions into account in reaching its decision and had listened to Mrs A's representations. He also concluded that the response to the complaint was appropriate.

However, whilst not upholding Mrs A's complaint, the Ombudsman did consider that there were areas of improvement for the Practice. These were that the Practice should have ensured that there was an adequate, contemporaneous record of the meeting where the decision to remove Mr A from the list was made; that it should ensure that correct contact details are given for the Health Board in letters informing patients of the decision to remove them from the list; and that in making decisions to remove patients from its list it should explicitly consider the impact of any disability under the Equality Act 2010.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201603084 - Report issued in May 2017

Mrs X complained that on 23 August 2015, two days after a total right knee replacement, her leg fell whilst on the ward. In September, Mrs X had an ultrasound scan that showed severe tendinopathy (wearing away of the tendon that joins the knee cap to the shin bone) and a possible low grade partial tear of the patellar tendon ("the tendon"). In November, Mrs X had another operation to repair the tendon. After this procedure, Mrs X said she was told that her tendon had been in a poor condition and had cysts under it, whose presence were explained to her as being because of wear and tear. A tear of the tendon had not been seen. Mrs X said that had her falling leg not caused this, the tendon's condition would have been noted and repaired in August.

The Ombudsman found that Mrs X's falling leg could not have led to a tear of her tendon and there had not been evidence of a visible tear on the September scan. Mrs X described a hyperextension injury. The Ombudsman also found that during the August procedure the condition of Mrs X's tendon would not have been visible and that the tendon is not explored during a total knee replacement. The Ombudsman did not uphold the complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201606009 - Report issued in May 2017

Mr X complained about the delay in providing treatment for his respiratory/sleep disorder, specifically a trial of CPAP (continuous positive airway pressure – a device to keep airways open while asleep).

The Health Board accepted there had been a delay of some eight months, and agreed to:

- a) apologise to Mr X
- b) provide him with an explanation for the delay and the actions it had taken to prevent a re-occurrence, and
- c) a payment of £200 in recognition of the delay and distress caused.

Superdrug Stores Plc – Clinical treatment outside hospital

Case Number 201700490 - Report issued in May 2017

Mrs A complained that Superdrug Stores Plc failed to acknowledge that any harm had been caused to her when responding to a complaint made about a dispensing error made at one of their pharmacies. Mrs A was also concerned that Superdrug Stores Plc failed to respond to an additional letter she sent to them. The Ombudsman considered the way in which Superdrug Stores Plc, as an Independent Community Health provider providing services on behalf of NHS Wales, had responded to the complaint.

It was noted that Superdrug Stores Plc acknowledged the dispensing error, apologised to Mrs A in respect of this and took appropriate actions to prevent a re-occurrence at a local level. However the Ombudsman agreed that the response provided by Superdrug Stores Plc could have included further consideration and comment on the impact of taking the wrong medication on Mrs A to ensure that the apologies offered were meaningful. There was also no evidence that the additional letter had been responded to.

On this basis the following Superdrug Stores Plc agreed to:

- a) provide a further letter of apology to Mrs A which adequately addressed Mrs A's concerns within one month of the date of this letter.

Cwm Taf University Health Board - Clinical treatment outside hospital

Case Number 201604388 - Report issued in May 2017

Mr A complained that his wife, Mrs Y, had been unsuccessful in obtaining an appointment with the Community Mental Health Team following referrals from her GP and having made requests directly. However, she had been advised by the Health Board that, as a former user of secondary mental health care services, she was entitled to refer herself back for further assessment if her condition deteriorated. On receipt of the complaint, the Ombudsman contacted the Health Board and it agreed to undertake the following in settlement of the matter:

- a) Offer Mrs Y an appointment for assessment

- b) Write to Mrs Y to apologise for the difficulties she has experienced
- c) Offer Mrs Y a redress payment of £250 in recognition of the unnecessary delay in obtaining an appointment
- d) Undertake an investigation of Mrs Y's difficulties in obtaining an appointment in accordance with the NHS complaints procedure.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201607681 - Report issued in May 2017

Mr A's complaint related to the issuing of his mother-in-law's, Mrs B, death certificate. Mr A also complained about a fall that Mrs B had suffered whilst admitted at Royal Gwent Hospital. Although the Ombudsman declined to investigate Mr A's complaint, he recognised that Aneurin Bevan University Health Board ("the Health Board") had already accepted that the level of communication afforded to Mr A and his family around the time was not as expected, and the discussions which took place about the death certificate on the ward had caused some distress and upset.

The Ombudsman also identified that no formal complaint response, in accordance with the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 ("the regulations"), had been provided in relation to Mrs B's fall and that no falls risk assessment was completed on her admission to hospital. The Ombudsman believed the failure to provide a response may have contributed to Mr A's decision to bring the complaint to him.

Because of this, the Ombudsman contacted the Health Board and it agreed to do the following within three months of the date of this decision:

- a) to provide confirmation of the training to be provided to staff members to ensure they are aware of the process to be followed when death certificates are issued on the ward and how the clinicians manage this. Supporting evidence to be provided
- b) to take steps to ensure the Coroner's guidelines are readily available to ward staff for their reference
- c) to remind staff of the importance of effective communication between clinicians and nursing staff on the ward and also between nursing staff and bereaved family members when dealing with the sensitive issue of issuing a death certificate and to take action to improve levels of communication to prevent similar misunderstandings from occurring in future
- d) to remind staff of the need for sensitivity and discretion when discussing matters with recently bereaved families and that, where possible, these conversations should take place in private
- e) to provide a full response, in accordance with the regulations, dealing with the fall. In particular, to take steps to further investigate and establish why no falls risk assessment was completed on admission and explain what action it proposes to take and/or has already taken to address any failings to avoid similar issues from occurring in the future

f) to consider its complaints handling, in particular, to establish why there was a failure to follow the regulations.

Powys Teaching Health Board – Continuing care

Case Number 201607726 - Report issued in May 2017

Ms X complained on behalf of her clients that Powys Teaching Health Board (“the Health Board”) had failed to properly consider their application for Continuing Healthcare for their mother. The Health Board had convened a Special Review Panel (“SRP”) to decide whether Ms X’s application should be considered as it was outside of its timescale due to a delay in applying for a Grant of Probate, which established their legal authority to make the claim. Ms X said that the Health Board had failed to take into account an unavoidable delay caused by the need to obtain a land valuation.

The Ombudsman considered that it may not have been possible for Ms X to have applied for the Grant of Probate without first obtaining a land valuation. It did not seem to the Ombudsman to have taken an unreasonable period of time, on the face of it, for Ms X to have obtained the valuation and provide a copy of the Grant of Probate to the Health Board.

The Health Board agreed to:

- a) Reconvene the SRP to reconsider its decision to close the Continuing Healthcare claim
- b) To do this within 30 days of the closure of the complaint
- c) To inform Ms X of the outcome and take any further action considered necessary.

Aneurin Bevan University Health Board – Clinical treatment outside hospital

Case Number 201700337 - Report issued in May 2017

Mr X complained that the Aneurin Bevan University Health Board (“the Health Board”) did not provide him with an assessment of his mental health needs for two and a half years. Mr X said that, following a complaint to the Health Board in 2017, it said that he could be seen by a Consultant Psychiatrist for assessment and that an appointment would be offered within the following two weeks (from 9 March 2017). In May, Mr X confirmed that he had yet not been offered an appointment.

The Ombudsman cannot consider a complaint which is simply that a patient has not been seen within the waiting list timescale. Whilst he might have considered a complaint that Mr X was not appropriately prioritised due to his clinical need, there was no evidence that this was the case. However, the Ombudsman was concerned that the Health Board had not provided Mr X with the appointment it had promised.

The Health Board agreed to:

- a) Apologise to Mr X
- b) Provide him with an explanation of the delay in his appointment

c) Offer him an appointment within two weeks of the closure of the case.

The Ombudsman considered this a reasonable settlement of the complaint.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201700959 – Report issued in June 2017

Mrs X complained that Hywel Dda University Health Board (“the Health Board”) failed to keep her informed of any problems arising, concerning her daughter’s planned operation. Mrs X also raised concerns over the lack of response to the complaint she originally raised with Health Board in January 2017.

The Health Board agreed to Provide Mrs X with its final response to her complaint by 10 July 2017 in settlement of Mrs X’s complaint at this stage.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital

Case Number 201701287 – Report issued in June 2017

Mr X complained to Cardiff and Vale University Health Board about the way in which a doctor conducted a capacity assessment on his grandson. The complaint was forwarded to Abertawe Bro Morgannwg University Health Board (“the Health Board”) as it is the employer of the doctor who is the subject of the complaint.

The Health Board subsequently failed to acknowledge or respond to Mr X’s complaint before he raised the matters with the Ombudsman’s office.

The Health Board agreed the following actions in settlement of the complaint:

- a) Issue the complaint response
- b) Apologise for the delay in responding to the complaint; and
- c) Offer a payment of £250 for the time and trouble in making the complaint to the Ombudsman.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201701557 – Report issued in June 2017

Mrs B complained on behalf of Mr G. The complainant was unhappy with the communication and apparent lack of progress by Betsi Cadwaladr University Health Board (“the Health Board”) regarding the fitting of a prosthetic leg.

The Ombudsman, after reviewing the evidence submitted, contacted the Health Board who confirmed that his ongoing treatment was due to be discussed at a multidisciplinary team meeting (“MDT”) on 23 June 2017.

The Health Board agreed to provide the complainant and his General Practitioner (“G.P”) with a copy of the minutes of the MDT that related to him which will include the proposals for his further treatment.

It agreed to supply the above mentioned information within ten working days of the meeting date, namely 7 July 2017 and provide the Ombudsman with a copy to confirm this.

Cardiff and Vale University Health Board - Clinical treatment outside hospital

Case Number 201700743 – Report issued in June 2017

Mr X complained that Cardiff and Vale University Health Board (“the Health Board”) had failed to respond to his complaint to it about the way in which a doctor conducted a capacity assessment on his grandson.

On receipt of the complaint, the Health Board correctly forwarded the complaint to Abertawe Bro Morgannwg University Health Board as that Health Board is the employer of the doctor who is the subject of the complaint.

However, the Health Board failed to inform Mr X that his complaint had been passed to Abertawe Bro Morgannwg University Health Board for it to respond to it.

The Health Board, in settlement of the complaint, agreed to complete the following actions by 10 July 2017:

- a) Apologise for failing to inform Mr X that his complaint had been forwarded to Abertawe Bro Morgannwg Health Board; and
- b) Remind relevant staff that complainants should be informed when their complaint has been forwarded to another organisation.

Benefits Administration

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Housing Benefit

Case Number 201606929 - Report issued in May 2017

Mr A complained about delays by Cardiff Council ("the Council") in providing evidence of his entitlement to Housing Benefit for the purpose of his application for student finance in 2016/2017. Consequently, in November 2016, he was awarded a Welsh Government Learning Grant, (which is means tested for Housing Benefit purposes) as opposed to the Special Support Grant (which is non-means tested). This had a detrimental impact on ongoing entitlement to Housing Benefit.

The Ombudsman found that the Council had already acknowledged its error and had agreed to take action to ensure that Mr A was not at a financial disadvantage. On receipt of the complaint, the Ombudsman contacted the Council. In recognition of the distress and inconvenience caused to Mr A, it also agreed to:

- a) apologise, and
- b) make a redress payment to him of £250.00.

Newport City Council – Housing Benefit

Case Number 201700333 – Report issued in June 2017

Miss R complained that, as a result of an official error on the part of Newport City Council ("the Council") when it was calculating her benefit entitlement, she was overpaid benefits. Although it acknowledged its error, the Council determined that the overpayments were recoverable and sought to recoup the monies. Ultimately, it was decided that the overpayments were non-recoverable but Miss R said that she had suffered significant stress and inconvenience in the meantime.

The Ombudsman found that the Council had accepted responsibility for the original mistake and was entitled to decide whether or not the overpayments were recoverable. However, the initial error did constitute maladministration and it precipitated a chain of events that took a significant amount of time and trouble to resolve.

The Council agreed to issue a further apology to the complainant and offer £200 financial redress for her time and trouble by 23 June 2017.

Community facilities, recreation and leisure

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Parks, outdoor centres and facilities Case Number 201607685 - Report issued in May 2017

Miss A's complaint related to the clearing of her allotment plot following the lapse of her tenancy agreement. Despite contacting Cardiff Council ("the Council") seeking advice on improvements, she complained that she was not provided with notice before the allotment was cleared and her personal belongings were not retained in safe storage. She complained that the Allotment Association failed to follow any procedure before and when clearing the plot. She also complained about the delay in dealing with her complaint.

Although the Ombudsman declined to investigate Miss A's complaint, he recognised that the Council had already accepted that there was no formal guidance on inspecting and/or clearing plots in the event of non-renewal of a tenancy agreement. It had agreed to provide guidance to the Allotment Association, particularly on the management of personal property at the end of the tenancy.

The Ombudsman also recognised that the Council had accepted that it had not dealt with the complaint in a timely manner and would arrange for guidance on complaints handling to be provided to the Allotment Association.

Because of this, the Ombudsman contacted the Council. The Council confirmed that paperwork relating to the plot inspections was missing. It agreed to do the following within two months of the date of this decision:

- a) to provide the Allotment Association with formal guidance on complaints handling and the procedure for clearing plots in the event of non-renewal of a tenancy agreement. Supporting evidence to be provided to the Ombudsman
- b) to provide Miss A with an apology for the way in which matters were handled, for the delays during the complaints handling process and the failure to keep her updated
- c) to offer Miss A a redress payment of £150 in recognition of the poor complaints handling and the uncertainty caused, due to the missing paperwork, about whether any of Miss A's personal items were present when the final inspection took place.

Caerphilly County Borough Council – Parks, outdoor centres and facilities Case Number 201607570 - Report issued in May 2017

Mr X complained that Caerphilly County Borough Council ("the Council") had not ensured that he had received an appeal regarding decisions taken by his local Allotment Committee to issue a Final Warning letter and a Notice to Quit in respect of his plot. In 2014, the Council had entered into a Devolved

Management Agreement ("DMA") with the Allotment Federation, which included a two stage appeals procedure to the Allotment Committee and then to the Allotment Federation. Mr X said that he was promised an appeal hearing by the Chairman of the Allotment Federation, but the matter was instead dealt with by the Council's allotment officer.

It did not appear to the Ombudsman that the Council had complied with the terms of the DMA. Accordingly, he asked the Council:

- a) To arrange, within 30 days, an appeal hearing by the Allotment Committee
- b) Should Mr X be dissatisfied with that decision, to swiftly arrange for an appeal hearing by the Allotment Federation
- c) To offer to pay Mr X £50 in respect of his time and trouble in dealing with the matter
- d) To issue reminders to staff about the content of the DMA, with particular reference to the appeal procedure
- e) To advise the Allotment Federation to remind all Allotment Committees that where Notices to Quit or Warnings are issued, a right of appeal exists and it must advise recipients accordingly.

The Council agreed to implement the above actions and the Ombudsman decided not to investigate Mr X's complaint on this basis.

Complaint Handling

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board - Health Case Number 201607452 - Report issued in April 2017

Mrs N complained about the length of time Betsi Cadwaladr Health Board ("the Health Board") was taking to provide a response to a complaint she submitted in August 2016 regarding a failure to diagnose a disorder of the immune system. A holding letter was issued on 19 October 2016 but despite chasing the matter throughout November and December Mrs N did not receive a response. On 23 January 2017 Mrs N was advised that the complaint response was being finalised and should be issued shortly, but it was not forthcoming.

The Ombudsman found that the length of time the Health Board had taken to respond to the complaint was excessive and unacceptable. During the Ombudsman's consideration, the Health Board issued its response, and agreed to undertake the following action in settlement of the complaint:

- a) provide an apology to Mrs N for the delays in complaint handling by 31 March 2017.

Newport City Council – Various other Case Number 201700312 - Report issued in April 2017

Mr X complained that Newport City Council ("the Council") had failed to reasonably consider a complaint prior to, during, and following an Employment Tribunal ("the Tribunal"). Mr X said that the Council were now "hiding behind" the completion of those legal proceedings.

As the substantive issues complained about related to employment matters that had been, or could have been, addressed at the Tribunal, the Ombudsman decided not to investigate them.

The Ombudsman did consider that the Council failed to manage Mr X's expectations when he initially raised his complaint by not providing sufficient information about the issues which could be addressed by the Tribunal. The Ombudsman also found that there was a delay in responding to Mr X following the conclusion of the Tribunal.

In settlement of Mr X's complaint handling concerns, the Council agreed to complete the following actions by 23 May 2017:

- a) Provide an apology for not adequately managing expectations from the outset
- b) Issue a further apology for the delay in responding to Mr X following the conclusion of the Tribunal.

Neath Port Talbot County Borough Council – Adult social services Case Number 201700427 - Report issued in May 2017

Mr M complained that he had received no response from the Neath Port Talbot County Borough Council

("the Council") to a formal complaint he submitted to it on 19 January 2017. The substance of the complaint related to a recent POVA investigation conducted by the Council. Mr M explained that he had received an acknowledgement which stated he would be contacted within ten days but received no further communication.

Subsequent to Mr M contacting the Ombudsman, the Council issued a Stage 1 complaint response on 9 May 2017.

The Ombudsman found that Mr M waited almost 14 weeks for the Council to issue its decision, and that no updates were forthcoming in the meantime. The Council agreed to undertake the following action, in settlement of the complaint:

- a) Offer £50 redress payment for the time and trouble in having to bring the complaint to the Ombudsman, within four weeks of the Ombudsman's decision letter.

Cardiff Council – Other

Case Number 201700610 - Report issued in May 2017

Mr C complained that Cardiff Council ("the Council") failed to respond to a formal complaint which was submitted by email on 3 April 2017. Although Mr C had received automated receipt emails, no formal acknowledgement and no response to the complaint had been forthcoming.

The Council's complaints policy requires it to acknowledge complaints within five working days and respond within 20 working days. It therefore agreed to undertake the following actions in settlement of the complaint, which the Ombudsman felt to be a reasonable resolution:

- a) apologise for the delay in acknowledging and responding to the complaint; and
- b) provide a response to the complaint by 23 May 2017.

Hywel Dda University Health Board - Health

Case Number 201606865 - Report issued in May 2017

Ms X complained that an employee of Hywel Dda University Health Board ("the Health") Board contacted her employer and suggested that she was an inappropriate person to have employed at the workplace and that she had been discriminating against one of her patients.

Ms X submitted a complaint to the Health Board in early November 2016 but it was not until 20 February 2017 that she received a response advising that an assessment would commence to determine if a formal investigation would be warranted. Ms X was also advised that it was unable to disclose its findings.

The Ombudsman contacted the Health Board and expressed its concerns with the length of time it took to relay this information to Ms X and to start its assessment. The Health Board agreed to:

- a) write to Ms X with its apologies for its delay

- b) notify Ms X of whether or not it finds that the contact to her employer was justified, and to
- c) consider an offer of financial redress should the outcome be that the contact was not justified.

Hywel Dda University Health Board – Health

Case Number 201701415 – Report issued in June 2017

Mr X complained that Hywel Dda University Health Board (“the Health Board”) had failed to respond to his complaint to it, made in April 2017, about an optician not providing a copy of his optician report to the DVLA.

The Health Board advised the Ombudsman that its investigation into Mr X’s complaint was ongoing, but that it had failed to acknowledge the complaint.

In settlement of the complaint, the Health Board agreed to (within one month):

- a) Apologise to Mr X for failing to acknowledge his complaint, and explain the current status of its investigation.

Aneurin Bevan University Health Board - Health

Case Number 201700672 – Report issued in June 2017

Miss X complained about the handling of her complaint about her late father, Mr X’s, care by Aneurin Bevan University Health Board (“the Health Board”).

The Health Board confirmed to the Ombudsman that its investigation was coming to a conclusion, and that it had sent update letters to Miss X.

The Health Board agreed to complete the following actions by 3 July 2017 in settlement of Miss X’s complaint:

- a) Issue its response to Miss X’s complaint
- b) Apologise to Miss X for the delay in responding to her complaint.

Cwm Taf University Health Board - Health

Case Number 201700888 – Report issued in June 2017

A solicitor complained the handling of a complaint about a failure to diagnose a spinal cord injury to their client, Mrs X, by Cwm Taf University Health Board (“the Health Board”).

The Ombudsman considered that, whilst the Health Board had received the complaint in August 2016, it had provided regular, monthly updates to the solicitor since October 2016.

The Health Board agreed the following actions in settlement of the complaint:

- a) Continue providing monthly updates
- b) Expedite the issuing of the complaint response; and
- c) Apologise for the time taken in investigating the complaint when issuing the complaint response.

Education

UPHELD

City and County of Swansea - School Transport Case Number 201600907 – Report issued in June 2017

Mr B's complaint centred on the City and County of Swansea Council's ("the Council") decision to end its contract with the Contractor responsible for transporting his son, Child C, to his out of county special needs school. Mr B noted the same personnel had taken his son to school since 2011. Mr B referred to the impact the changes had had on his son who has been diagnosed with autism spectrum disorder. Mr B also had concerns about inadequacies in the Council's monitoring of its out of county school home to school transportation contracts.

The Ombudsman concluded that the Council was entitled to terminate the contract when a breach occurred. He did not uphold this part of Mr B's complaint.

The Ombudsman concluded the Council's monitoring of its out of county home to school contracts was insufficiently robust, which the Council had previously acknowledged. The Ombudsman found the failings amounted to maladministration, but concluded that these had not caused an injustice to Child C. This part of Mr B's complaint was also not upheld.

The Ombudsman identified shortcomings in the Council's complaints handling. He upheld this part of Mr B's complaint.

The Ombudsman recommended that the Council:

- a) apologise to Mr B, and
- b) review its contract monitoring in this area.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Special Educational Needs Case Number 201605511 - Report issued in May 2017

Ms A complained that Cardiff Council ("the Council") had failed to properly assess her son's individual educational needs before refusing her request for him to be allowed an "out of chronological year" admission to school. Ms A also raised concerns about how the Council had handled her requests to appeal its decision and her subsequent complaint about the matter.

Although the Ombudsman identified some administrative failings, he did not find that they were material to the Council's decision to refuse Ms A's request. In order to remedy the failings identified, the Council agreed to undertake the following in settlement of the complaint:

- a) apologise to Ms A for the failure to provide her with a written statement of reasons for the decision

to refuse her request; for the lack of clarity about her appeal rights and how her complaint was being considered and for the poor written response to her complaint.

b) offer Ms A a redress payment of £250 in recognition of the uncertainty and frustration caused by those failings and her time and trouble in pursuing the complaint.

c) review its policy and written procedure to support parents and decision makers when considering out of chronological year requests.

Conwy County Borough Council – Other

Case Number 201700727 – Report issued in June 2017

Mr A complained about a decision taken by the Conwy County Borough Council (“the Council”). Specifically he complained that an irregular process was followed and that a lack of proof was applied to the decision making process. Mr A referred to the findings of an independent investigation commissioned by the Council in respect of his complaints to evidence his ongoing concerns.

Whilst the Ombudsman considered that the decision taken by the Council was a decision that it was entitled to take and appeared to be properly made, he agreed that the independent investigation had identified some administrative failings at various points in time. Having considered the findings the Ombudsman concluded that little further could be achieved by investigating this matter. However the Ombudsman felt that the Council should recognise the failings and take the following actions in consequence within three months:

a) Apologise to Mr A in respect of the failings identified and recognise the impact that on him.

b) Provide Mr A with an explanation of the “decision”

c) Finalise and implement a formal policy relating to the way in which decisions of this nature are taken.

City and County of Swansea – School Transport

Case Number 201606454 – Report issued in June 2017

Mrs X complained, via her advocate, about the Council’s Additional Learning Needs (‘ALN’) Panel’s decision to refuse her daughter, M, free home to school transport. The advocate considered the City and Council of Swansea (“the Council”) had failed to have due regard to M’s disability and her individual and specific needs.

Following discussion with the Council, it held a further ALN Panel to specifically consider these issues. It recommended that home to school transport be provided to M based on her age, disability, individual circumstances and the availability of a safe walking route to school.

The investigation was discontinued and the complaint considered as a settled based on the action the Council had already taken, and the additional actions it agreed to take, which included a review of its Home to School Transport Policy in light of its ALN Panel recommendation.

Environment and environmental health

NOT UPHELD

Natural Resources Wales – Pollution and pollution control measures

Case Number 201602861 - Report issued in June 2017

Mr A complained to the Ombudsman that Natural Resources Wales (NRW) had failed to take action against his neighbour to require him to move a heap of horse manure that was in close proximity to his dwelling. Mr A explained that the manure heap was excessively large, was in place permanently and caused him considerable nuisance.

The investigation found that NRW had powers to regulate manure heaps if they were to be disposed of as a waste product. However, in this case since the manure was used as a fertilizer to improve the quality NRW had no regulatory role. It was also found that NRW could also take regulatory action if the manure heap compromised the quality of the ground water. However as the heap posed no significant risk to the groundwater, it was not a matter NRW could regulate. Whilst the Ombudsman had sympathy for the position Mr A found himself in, he found that NRW was not the appropriate organisation to deal with Mr A's concerns. The complaint was therefore not upheld.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Noise and other nuisance issues

Case Number 201607609 - Report issued in April 2017

Mr D complained that Cardiff Council ("the Council") had failed to consistently deal with complaints he had made of noise nuisance caused by neighbours. He also complained that the Council did not advise him of the time period that he was allowed access to its Noise Nuisance Emergency Line nor when this time period was due to expire.

The Ombudsman ascertained that the Council had advised him that noise monitoring equipment was unsuitable due to several sources of music in the block of flats where he was resident. It was also noted that the Council had amended its initial response letter to complainants to provide more specific detail of investigation/monitoring time periods.

The Council agreed to voluntarily settle this complaint by:

a) amending its procedure to ensure that it contacts a complainant as part of its review process at the end of any Emergency Line Access period during any complaint of noise nuisance.

This would be implemented within 20 working days of the date of the letter.

The Ombudsman considered that this was a reasonable early resolution to this complaint.

Flintshire County Council – Pollution and pollution control measures

Case Number 201607566 - Report issued in April 2017

Mr A complained that he was issued a Fixed Penalty Notice ("FPN") by Flintshire County Council ("the Council") which he denied. Mr A also raised concerns about the Council's handling of his complaint. Mr A had the right to make representations to the Council within 14 days of the issuing of the FPN. From the information provided to the Ombudsman, it did not appear that Mr A did so in line with the instructions provided on the FPN.

In regards to the Council's complaint handling, it was evident that there was a delay in responding to the complaint, and the complainant had to contact the Council on numerous occasions to obtain updates. Furthermore, the Council's Stage 1 response was provided by way of an unrecorded telephone call. This led to the Council being unable to consider its own complaint response at Stage 2 of its procedure.

In settlement of Mr A's complaint, the Council agreed to:

- a) Provide a written apology to Mr A for the delay in responding to his complaint, and for the lack of updates during that delay
- b) Provide a further written apology for being unable to adequately address Mr A's concerns at Stage 2 of its complaints process due to the Stage 1 response being provided by an unrecorded telephone call
- c) Offer a payment of £50 to Mr A for the time and trouble in making his complaint to the Ombudsman.

Powys County Council – Refuse collection, recycling and waste disposal

Case Number 201604301 - Report issued in May 2017

Mr X complained that his recyclable and non-recyclable waste was not being collected and he had not been provided with a large grey wheeled bin, as he had requested.

Powys County Council ("the Council") arranged for those collections to be undertaken and arranged for a large wheeled bin to be provided to Mr X. As a result, the matter was regarded as resolved and the investigation of the complaint was discontinued.

Flintshire County Council - Flooding / Flood Damage

Case Number 201700476 – Report issued in June 2017

Mr and Mrs A complained that Flintshire County Council ("the Council") had failed to act to resolve a problem with the drainage system servicing their property. Mr and Mrs A said that they had complained to the Council following flooding of their home in 1999, 2003 and again in July 2016. They were informed that the cause of the flooding was a blockage in the drainage system that could not be cleared through rods and flushing. Mr and Mrs A said that they had been in regular contact with the Council since that time, and had consistently been told that the works would be completed, but no action had been taken by the time they approached the Ombudsman on 19 April 2017.

The Ombudsman found that the Council's formal complaint process had not been exhausted, and that since

Mr and Mrs A contacted him, the Council had already begun work to resolve the problem.

The Council agreed to undertake the following actions, in settlement of the complaint:

- a) Carry out a Stage Two investigation of the complaint within four weeks of the Ombudsman's decision; and
- b) Provide a commitment to ensuring that the works are completed satisfactorily

Cardiff Council - Refuse collection, recycling and waste disposal Case Number 201701059 – Report issued in June 2017

Ms X complained that for the past two years Cardiff Council ("the Council") has failed to collect her mother's waste although she is on "assisted lift".

The Council advised the Ombudsman that it had identified the waste was being placed in an obscure location where operatives can easily miss it. The Council offered to meet with Ms X and her mother to discuss where the waste needs to be presented. Concerns were expressed to the Council about why this issue wasn't already raised with Ms X and her mother.

The Council has agreed to undertake the following in settlement of this complaint:

- a) Provide an apology for the inconvenience caused to both Ms X and her mother
- b) To meet with Ms X and her mother to discuss the correct location to place the waste; and
- c) Ensure Ms X's mother's property had been placed on the "Priority List" to ensure collection.

The Council also advised this issue had been communicated to the crew who must ensure that when a collection takes place it is to be reported to a supervisor and that any further missed collections will result in action being taken against them.

Finance and taxation

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Powys County Council – Finance and taxation

Case Number 201607021 - Report issued in April 2017

Mr A complained that Powys County Council (“the Council”) failed to provide him with a response to his letter of 5 September 2016, in which he had complained about a recent rebate of council tax that he felt had been calculated incorrectly. Furthermore, having agreed with the Ombudsman in January 2017, that it would provide Mr A with a response to his concerns, by March 2017, it had not done so.

On receipt of the complaint, the Ombudsman contacted the Council. He found that there had been a misunderstanding by the Council about what it was required by the Ombudsman to do. He was satisfied that this was as a result of human error rather than any procedural failing. In recognition of the complaint handling delays, the Council agreed to:

- a) provide Mr A with the outstanding response to his complaint; and
- b) apologise and make a redress payment to him of £50.00.

Cardiff Council – Finance and Taxation

Case Number 201700605 – Report issued in June 2017

Mr and Mrs A complained about Cardiff Council’s (“the Council”) handling of their concerns in respect of their council tax account.

On three occasions Mr and Mrs A asked the Council for information so that they could understand the payments and the reasons for the balance on their council tax account.

The Ombudsman considered that the Council could have given Mr and Mrs A a better explanation and breakdown of their council tax account.

The Council agreed to take the following action in settlement of the complaint:

- a) The Council will contact Mr and Mrs A to arrange a meeting at its offices to discuss their council tax account
- b) If it is considered necessary, to arrange for the services of a translator to be present
- c) To provide Mr and Mrs A with help to understand their council tax responsibilities and a full breakdown of their payments
- d) Apologise to Mr and Mrs A for not providing sufficient information earlier

Housing

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cartrefi Cymunedol Gwynedd – Repairs and maintenance Case Number 201606463 - Report issued in April 2017

Mr D complained on behalf of his mother and sister. His mother was a tenant of Cartrefi Cymunedol Gwynedd ("the Group"). A problem with damp was initially reported to the Group in 2012. Initial visits were made but, work was never undertaken to remedy the problems until the issue arose again during 2015. Two surveys were undertaken but, at the time of his complaint submission to the Ombudsman, no works had been undertaken to tackle the damp.

The Ombudsman, after reviewing the evidence submitted, contacted the Group which agreed to implement the following actions within six weeks (providing evidence of compliance to the Ombudsman):

- a) Write a letter to his mother and sister apologising for the delays in undertaking the work necessary to remedy the damp problems
- b) Make a redress payment of £2,520 to his mother in recognition of the conditions that she and his sister had to reside in, and
- c) Prepare a work schedule of outstanding works to be undertaken. This would be shared with him Mr D in order to provide a timetable of intended dates for works to be undertaken/completed.

Monmouthshire Housing Association – Repairs and maintenance Case Number 201603232 - Report issued in May 2017

Mr A's complaint concerned disrepair and anti-social behaviour both in and around the area of his accommodation. Mr A said that the conditions at the flat became so 'intolerable' that he was forced to vacate the property.

Monmouthshire Housing Association ("the Housing Association") accepted that the repairs were not completed in a timely manner or communicated to Mr A in a satisfactory manner. The Housing Association agreed to waive some of Mr A's rent thus reducing the rent arrears that Mr A had accumulated.

Cardiff Council – Repairs and maintenance Case Number 201700426 - Report issued in May 2017

Mr E complained about a fault with the communal doors at his property that he reported to Cardiff Council ("the Council"). He was informed that it would be resolved within five working days. Mr E explained that the Council failed to repair the fault within that time period, although when he complained to the Council and requested compensation it advised him the doors were repaired on the fifth day.

The Ombudsman found that the door was not repaired until the sixth working day after Mr E had reported it.

The Council agreed to undertake the following actions within two weeks of the date of the Ombudsman's official notification, in settlement of the complaint.

- a) apologise for misleading the complainant as to the date the fault was repaired; and
- b) make a new decision regarding Mr E's request for compensation.

Planning and building control

NOT UPHELD

Carmarthenshire County Council - Unauthorised development - calls for enforcement action etc.
Case Number 201507076 - Report issued in June 2017

Mrs C complained to the Ombudsman that Carmarthenshire County Council ("the Council") had incorrectly granted planning consent for an agricultural track in 2011. She also complained that the Council had failed to take action to prevent her neighbouring land owner from quarrying minerals to construct the track that had been previously consented and that the materials being quarried were being exported away from the agricultural unit. Finally Mrs C complained the Council had allowed the land owner to perform engineering activity on a protected site in 2014 and again in 2015 in another part of the farm.

The Ombudsman found that the planning consent granted for the construction of an agricultural track in 2011 was given without evidence of maladministration. He also found that the Council had not acted maladministratively when it decided that the quarrying activity to construct the track had been permissible under agricultural permitted development rights and that the Council had not acted maladministratively in deciding not to take enforcement action. Finally, whilst the Ombudsman found that the Council had failed to inform Natural Resources Wales (NRW) of the landowner's activities on the protected site, it had taken appropriate enforcement action to ensure the activity ceased and the land was restored. In view of the above the Ombudsman did not uphold the complaint.

Roads and transport

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Gwynedd Council – Road maintenance/road building Case Number 201607024 - Report issued in April 2017

Mr G complained that Gwynedd Council (“the Council”) failed to address his complaints relating to an abandoned vehicle and street maintenance of the area around his home. Mr G made several complaints to the Council between August 2016 and February 2017, but although the Council acknowledged his requests, the Council failed to provide a full response.

The Ombudsman found that the Council had overlooked Mr G’s complaints and failed to escalate his complaint appropriately when he raised further concerns.

The Council agreed to undertake the following actions in settlement of the complaint:

- a) apologise for the delay in providing a response
- b) offer financial redress of £50 for Mr G’s time and trouble in raising the complaint; and
- c) provide a full Stage 2 response to Mr G’s concerns within four weeks.

City and County of Swansea - Other Case Number 201606818 - Report issued in May 2017

Mr A complained about the decision and actions of City and County of Swansea (“the Council”) when it moved his car which had been legally parked outside his home address. The Council had moved Mr A’s car in order to carry out work to a neighbouring property and in doing so the complainant said that his car had been damaged. Mr A also complained that the Council had not given him relevant notifications regarding works being undertaken.

Furthermore, Mr A also complained about the amount of time he had spent trying to get answers to his complaint and that questions he had asked were not answered during the complaint process.

The Ombudsman concluded that he could not deal with all the complaint matters. Nevertheless, the Ombudsman considered there to be some complaint handling failings which might be resolved by actions on the part of the Council. It agreed, within one month of the date of this decision to:

- a) Provide a written apology to the complainant which would take into account the complaint handling failings identified, including its failure to respond to pertinent questions and the unnecessary time and trouble the complainant had to spend in order to get their complaint fully answered
- b) Provide financial redress of £50.00 to the complainant in recognition of the time and trouble spent making the complaint, within one month of this decision.

Cardiff Council - Parking

Case Number 201701180 - Report issued in June 2017

Mrs H complained that she had to pay twice for car parking as she had been incorrectly informed that she could not park at a Cardiff Council ("the Council") car park. Mrs H also complained that the refund she had been offered by the Council was yet to be paid.

The Ombudsman considered that the Council had responded to Mrs H's complaint in a timely manner, and had offered to refund Mrs H the amount paid at the Council car park.

However, the Council did not offer an apology to Mrs H for the inconvenience that was caused, nor had the refund been issued.

The Council agreed the following in settlement of the complaint:

- a) Expedite the initial refund
- b) Apologise for the inconvenience caused by the car parking error; and
- c) Offer a further £10 for the time and trouble in making the complaint to the Ombudsman.

Newport City Council – Other

Case Number 201700376 – Report issued in June 2017

The first aspect of Mrs X's complaint concerned her observation that Newport City Council ("the Council") do not appear to have applied due process after a resident proposed a road renaming.

The second aspect concerned the Council's lack of communication in relation to the complaint Mrs X raised, and the delay in providing Mrs X with its response after a Council Officer informed her of an error on the Council's part.

On contacting the Council, it agreed to the following:

- a) Provide Mrs X with an apology for the delay and in recognition of its poor complaint handling
- b) Provide Mrs X with a time and trouble payment of £50

Self-funding care provider

NOT UPHELD

A Care Home in the area of Abertawe Bro Morgannwg University Health Board – Care Homes
Case Number 201602543 - Report issued in April 2017

Mr X complained about the nursing care provided to his late mother ("Mrs Y") at a Care Home in the area of Abertawe Bro Morgannwg University Health Board ("the Care Home"). He said that, between August and November 2015, the level of nursing care provided to Mrs Y was insufficient, which ultimately led to her death.

The investigation found that Mrs Y's risk of falls was appropriately assessed by the Care Home upon her admission and that an appropriate care plan was put in place to meet her needs. There was no evidence to suggest that Mrs Y required a higher level of supervision or that, had it been in place, it would have prevented her from falling.

The Ombudsman was satisfied that the care and treatment provided to Mrs Y by the Care Home was within the range of reasonable practice. Consequently, the complaint was not upheld and no recommendations were made.

Allied Healthcare – Domiciliary Care

Case Number 201601455 – Report issued in June 2017

Mr A complained about the cancellation of domiciliary care visits for his adult son, Mr B, between September 2015 and January 2016. He said that there were numerous occasions during this period when Allied Healthcare had failed to provide a service for Mr B and that Mr and Mrs A, as his parents, had to provide the care instead.

The Ombudsman considered information provided by Mr A and Allied Healthcare. He also obtained advice from one of his Nursing Advisers.

The Ombudsman found that there had been some acknowledged difficulties with the rota. It was noted that the staff provided were sometimes not the family's preferred experienced carers. However, the staff provided by Allied Healthcare were appropriately trained in that they had completed the Manual Handling passport (modules A-F) which would be required. The Ombudsman did not uphold the complaint.

Social services – Adult

NOT UPHELD

Pembrokeshire County Council - Services for People with a disability inc DFGs

Case Number 201603695 – Report issued in June 2017

Mr X complained about Pembrokeshire County Council's ("the Council") Social Services Department. In particular, he raised concerns that the Council failed to:

- a) Undertake its own recommendations arising from his complaint;
- b) Provide his daughter ("Ms Y") with a suitable sling;
- c) Respond to his email, dated 30 June 2016, in which he outlined his ongoing concerns.

The Ombudsman did not uphold the complaints and no recommendations were made.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Newport City Council – Services for vulnerable adults

Case Number 201607041 - Report issued in April 2017

Mrs L complained that Newport City Council ("the Council") reduced her sister's respite care package but made its decision without seeing her and before carrying out the appropriate assessments. On appeal the care package was increased slightly, but not to the previous level and Mrs L explained this had a detrimental effect on her sister and her carers. The Council refused to escalate Mrs L's concerns through the statutory Social Services Complaints Procedure on the grounds that this process cannot be used to lodge an appeal against a decision.

The Ombudsman found that Mrs L's concerns around the process followed in making the decision, particularly in relation to the timeline of the assessments that were made, were matters that should be considered via an independent review, and were matters appropriate to be considered under the Social Services Complaints process.

The Council agreed to undertake the following action in settlement of the complaint:

- a) Commission a Stage 2 Social Services Complaint Investigation within 12 weeks of the Ombudsman's decision.

Blaenau Gwent County Borough Council – Services for people with a disability

Case Number 201701326 - Report issued in June 2017

Mrs X complained that her mother, Mrs Y, received a grant from Blaenau Gwent County Borough Council ("the Council") in 2013 to have a disabled shower fitted. The cement under the shower had cracked in recent months, which caused a leak. In turn, the leak caused the lino in the bathroom to rise at the edges,

causing a potential tripping hazard.

Mrs X was informed by the Council that as the works were originally completed in 2013, the warranty period had elapsed, therefore it was not liable.

Although liability is an issue for the courts, and despite the original works being completed in 2013, the Council agreed with the Ombudsman to undertake the following in settlement of Mrs X's complaint:

a) Visit Mrs Y's property as soon as possible, and carry out minor works to rectify the problem with the lino.

Social services – Children

UPHELD

Caerphilly County Borough Council - Other

Case Number 201600740 - Report issued in April 2017

Mr and Mrs X complained Caerphilly County Borough Council ("the Council") failed to conduct an investigation into the child protection issues they raised in 2011 following the death of their son, Q whilst on an educational excursion in Spain with his College.

The investigation found that whilst the outcome would have been the same had the safeguarding process been completed in 2011, there was an unreasonable delay in the decision making process and the communication of that decision to all parties. Consequently, it resulted in a missed opportunity, to ensure that the circumstances of Q's death were fully considered in accordance with the procedures relevant at that time, as well as any subsequent review or investigation.

Additionally, the investigation found that an opportunity had been missed to contact the College and not only ensure that a thorough investigation had been undertaken but also the future safety of the students. The complaint was partly upheld.

It was recommended that the Council apologise to Mr and Mrs X and provide them with the details of the changes to its child protection process, in order to provide them with the reassurance that these failings should not be repeated.

Newport City Council - Other

Case Number 201600699 - Report issued in June 2017

Mr and Mrs D complained about Newport City Council's ("the Council's") social and foster care services. In particular, the Ombudsman considered the following complaints:

- The Council's handling of Mr and Mrs D's Stage 1 and Stage 2 complaint;
- The Council declined to provide funding for them to access the Independent Support Service;
- The Council declined to pay them the foster-carer's allowance, for the period between the removal of the children and final notification of the decision not to re-approve them as foster carers; and
- The Council was slow to provide a formal statement explaining the rationale behind the decision to remove the children from their care.

The Ombudsman partially upheld Mr and Mrs D's complaint relating to complaint handling by the Council. He recommended that the Council provides Mr and Mrs D with a letter of apology.

The Ombudsman did not uphold the other elements of Mr and Mrs D's complaint.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council - Children in care/taken into care/'at risk' register/child abuse/custody of children Case Number 201607804 - Report issued in May 2017

Mr R complained that Cardiff Council ("the Council") failed to notify or consult him ahead of its decision to seek a Special Guardianship Order, which was taken against his wishes and without an appropriate assessment. Mr R raised his concerns on 16 February 2016 but they were not formally acknowledged until 22 September 2016 following his request for an update, and despite continued requests for contact, Mr R had not received a response.

The Ombudsman found that the Council failed to investigate or provide any explanation regarding the delay in responding to his complaint. Furthermore, although the Council had issued a response in October 2016, it failed to reissue that response when Mr R again sought an update on the consideration of his complaint. Consequently, Mr R waited over a year for a response to his complaint.

The Ombudsman considered that such a delay is significant and unacceptable and amounts to maladministration on the part of the Council. The Council agreed to undertake the following actions in settlement of the complaint:

- a) Apologise and provide a full explanation for the complaint handling failures
- b) Re-issue the complaint response
- c) Offer financial redress at the sum of £300; and
- d) Complete these actions within three weeks of the Ombudsman's official notification of the decision.

Rhondda Cynon Taf County Borough Council - Other Case Number 201700257 – Report issued in May 2017

Ms V complained about the way Rhondda Cynon Taf County Borough Council ("the Council") dealt with concerns relating to a mobile phone that was provided to her son to maintain paternal contact. After he sent a sexualised text message, the phone was taken away by a Social Worker and returned to his father. Ms V explained that she raised concerns both at the time and since, but the Council failed to investigate or provide her with an explanation of the way the matter was handled.

The Ombudsman found that the Council had record of Ms V raising the issue with Social Workers both informally and in a formal complaint in January 2017, but no full or formal explanation had been provided.

The Council agreed to undertake the following action in settlement of the complaint:

- a) provide a meaningful response to address Ms V's concerns about how it dealt with the matter of the phone, and the text message

Rhondda Cynon Taf County Borough Council - Children in care/taken into care/'at risk' register/child abuse/custody of children

Case Number 201700675 - Report issued in June 2017

Mrs A complained that Rhondda Cynon Taf County Borough Council ("the Council") had failed to follow its complaints procedure when dealing with her complaint. In particular, she complained that it did not progress her complaint to a Stage 2 investigation at her request.

Although the Ombudsman declined to investigate Mrs A's complaint, he recognised that regulation 17 of the Social Services Complaints Procedure (Wales) Regulations 2014 compels the Council to progress a complaint to formal investigation (Stage 2) if requested by the complainant.

Because of this, the Ombudsman contacted the Council. It agreed to carry out a Stage 2 investigation of Mrs A's original complaint in accordance with the regulations, with supporting evidence to be provided within two months of the date of this decision.

Rhondda Cynon Taf County Borough Council - Children in care/taken into care/'at risk' register/child abuse/custody of children

Case Number 201701374 - Report issued in June 2017

Ms X and Ms Y complained that a Rhondda Cynon Taf County Borough Council ("the Council") Social Worker lied to them, agreed meetings had not been set up, and that their children have missed contact and that this has not been followed up with the children's carers.

The Ombudsman found that Ms X and Ms Y were yet to formally raise the matters with the Council. The Council agreed to consider the complaint at Stage 1 of its Social Services complaints procedure. The Council also suggested the following actions which the Ombudsman considered to be reasonable:

- a) The children be offered an advocate to ensure their views around contact are being reflected by their carers and Social Worker and to reassure the family that they have been spoken to independently
- b) Meet with the family to discuss the outcome of the discussion with the children and agree a way forward.

Various Other

EARLY RESOLUTION

Monmouthshire County Council – Poor/no communication or failure to provide information

Case Number 201606072 - Report issued in April 2017

Mr and Mrs X complained that they believed that Monmouthshire County Council (“the Council”) had acted with maladministration in addressing their concerns about the maintenance and cleaning of the drains within the vicinity of their property. They also complained about the timeliness and accuracy of the responses that they had received in relation to this matter from the Council.

The Ombudsman found that there had been a failing to recognise and handle Mr and Mrs X’s correspondence as a complaint and provide a formal response to their allegations. After contacting the Council, the Ombudsman recommended the following early resolution to the complaint, which the Council agreed to undertake by 29 May 2017:

- a) Provide a letter of apology to Mr and Mrs X for the delay in dealing with their correspondence as a complaint
- b) Provide a comprehensive Stage 2 complaint response letter addressing Mr and Mrs X’s complaint about the cleaning and maintenance of drains in the vicinity of their property
- c) Provide a redress payment of £100 to reflect the time and trouble Mr and Mrs X have taken in pursuing their complaint with this office.

Cardiff Council – Other

Case Number 201701278 – Report issued in June 2017

Mr C complained that Cardiff Council (“the Council”) had failed to address his concerns or answer the queries he had put to it. Mr C had made a Freedom of Information request in January 2017 which had given rise to a query relating to the Council’s policy on the retention of documentation. However, despite contacting the Council on a number of occasions he had not received a response.

The Ombudsman found that there has been some confusion as to which department should respond to the query, which had resulted in a delay on the part of the Council in dealing with it.

The Council agreed to undertake the following actions in settlement of the complaint:

- a) Acknowledge the matter and clarify that the Council will now consider the complaint;
- a) Apologise for the confusion and delays; and
- c) Provide a response to the complaint and the query by 30 June 2017.

More information

Full reports can be found on our website: www.ombudsman-wales.org.uk. If you cannot find the report you want, you can request a copy by emailing ask@ombudsman-wales.org.uk.

We value any comments or feedback you may have regarding The Ombudsman's Casebook. We would also be happy to answer any queries you may have regarding its contents. Any such correspondence can be emailed to Matthew.Aplin@ombudsman-wales.org.uk or Lucy.John@ombudsman-wales.org.uk or sent to the following address:

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