

The Ombudsman's Casebook

Issue 30 November 2017

News

NHS Complaints Rise by 8%

Figures from the 2016/17 PSOW Annual Report show an 8% rise in complaints against NHS bodies, with health complaints making up 38% of the office's caseload.

Overall casework statistics show that there was 6,804 complaints and enquiries made during the financial year and that overall casework has increased by 75% over the past six years.



Annual Report Executive Summary

A summary of the 2016/17 Annual Report of the Public Services Ombudsman for Wales

INNOVATION P IMPROVEMENT P INFLUENCE

Public Services Ombudsman (Wales) Bill

The new bill was introduced to the Assembly by the Chair of the Finance Committee, Simon Thomas, on Monday 2nd October.

The Bill will now be considered by the Assembly's Equality, Local Government and Communities Committee at the first stage of the law-making process. For further information on the bill please visit [here](#) and for the legislative timetable please visit [here](#).

Local Government Sounding Board

After the success of the service user and health sounding boards, we recently established our third group for the local government sector.

Members include chief executives, Ombudsman contact officers, monitoring officers, the WLGA and representatives from various local authority departments such as planning and development; social services; children & young people and environment.

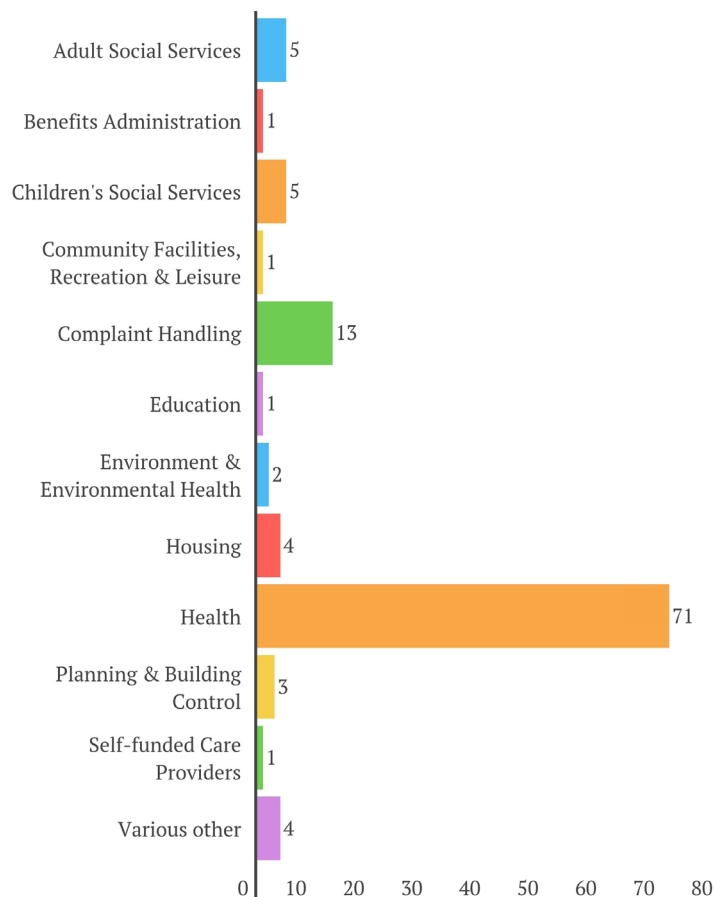
The first meeting took place on 11 September and useful discussions took place on a variety of topics including shared services and the improvement officer role.

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Casebook in numbers

These infographics illustrate the cases closed between July and September 2017 by subject and outcome. They do 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.



3



26



27



53

● Public Interest
 ● Upheld
 ● Not Upheld
 ● Early Resolution

What's in the postbag?

The casebook contains summaries of all PSOW closed cases, but the office can often become aware of public service issues developing at the front end of our service where the Complaint Advice Team (CAT) deals with complaints and enquiries at the initial stage.

In the Ombudsman's latest thematic report, '[Ending Groundhog Day: Lessons from Poor Complaint Handling](#)', he found in too many of the cases that come to this office, service failure is compounded by the respective organisation failing to investigate the original complaint correctly.

The following two recent issues which have emerged and are examples of this and the Ombudsman wishes to highlight them to ensure they are addressed by local authorities.

Planning

We are seeing a number of complaints relating to planning enforcement matters being automatically referred back to local authorities' Planning Departments to deal with.

Some of these complaints can contain different elements - for example, regarding delay or service failure - and should be addressed by the body as a corporate complaint. As they are being directed to Planning Departments by officials, these elements are not being dealt with. It also gives the impression to complainants that those concerns are not being objectively considered in that officers involved in the substantive matter are permitted to "oversee themselves".

In our thematic report we highlighted the importance of effective governance to ensure the person investigating is sufficiently independent of the events complained about.

Social Services

Our caseload shows that there is an inconsistent approach being applied by local authorities across Wales when deciding to "allow" a complainant to go through a stage 2 independent investigation rather than simply accepting the complainant's right to one.

There is anecdotal evidence from our caseload that some local authorities are refusing stage 2 investigations when complainants are seen as being "difficult." This is clearly unacceptable as often this client group is particularly vulnerable.

Guidance on the formal investigation stages can be found in both the Social Services Complaints Procedure (Wales) Regulations 2014 and in Welsh Government Guidance, 'A guide to handling complaints and representations by local authority social services'.

The latter states:

"Whilst the majority of complaints and representations should be resolved by Local Resolution, the complainant should be made aware that they have the right to choose that their complaint be dealt with as a Formal Investigation."

This is something the Ombudsman would expect local authorities to address as a matter of urgency and the office will be monitoring new complaints received to see if there are further examples.

Health

The following summaries relate to public interest reports issued under Section 16 of the Public Services Ombudsman (Wales) Act 2005.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201604327 - Report issued in July 2017

Mr D complained to the Ombudsman about the manner in which Cwm Taf University Health Board (“the Health Board”) dealt with his complaint under NHS complaints procedure about the care his late mother (“Mrs D”) received. Mr D was particularly concerned about the length of time it took for the Health Board to respond to him after it had identified that it had breached its duty of care towards his mother and with the response he ultimately received from the Health Board.

The Ombudsman found that the Health Board had taken too long to investigate the matter under the relevant redress arrangements, had misplaced Mrs D, records and failed to inform Mr D when offering him a full and final settlement, that the clinician whose advice they had relied upon in its response letter to Mr D did not have access to Mrs D’s records. The Ombudsman found that the delay in dealing with the redress issue coupled with the lack of transparency in the Health Board’s redress response to Mr D amounted to clear maladministration leading to injustice to Mr D.

The Ombudsman upheld the complaint.

He recommended the Health Board:

- a) apologise to Mr D
- b) provide him with redress of £2000 for the distress he and Mrs D would have experienced as a result of the shortcomings identified
- c) provide Mr D with redress of £500 for his time and trouble in pursuing the complaint over a prolonged period of time
- d) provide Mr D with free legal advice and arrange for joint instruction of an independent clinical adviser to consider whether Mrs D had suffered harm as a result of the shortcoming the Health Board identified
- e) if it was not possible to arrange such an instruction in a timely manner, that Mr D be paid a further £1500 in redress to reflect the lost opportunity to have his mother’s care considered appropriately
- f) ensure that all relevant staff are formally reminded of their duty to be open and transparent at all times with patients and their relatives.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case number 201603927 – Report issued in August 2017

Mr Y complained about the care his mother, Mrs X, received from Betsi Cadwaladr University Health Board (“the Health Board”). Mrs X was admitted to hospital in 2015. She was very ill and it had been

agreed between staff and the family that she was for supportive care only, i.e. palliative care, to improve comfort and quality of life. Mr Y complained that despite this, Mrs X was twice transferred to a different hospital for a CT scan.

On the second occasion, there was no bed available for Mrs X when she arrived. She sadly died on a trolley waiting for a bed. Mr Y also complained about the time taken by the Health Board to provide its complaint response and that the response was sent to the wrong address.

The Ombudsman upheld the complaints about clinical care. In light of the plan for supportive care, a CT scan would not have altered the approach to Mrs X's care. Despite that, she was twice unnecessarily transferred many miles to another hospital for a CT scan which did not take place. The Health Board's approach was detrimental to Mrs X's well-being and the manner of her death. The Ombudsman concluded that Mrs X's human rights were likely to have been compromised. Her dignity at the end of her life was not respected and she did not have sufficiently considerate care in her final days. The decisions to transfer her for scans which would not have changed the approach to her care failed to take account of her needs as an individual.

They failed also to take account of Mrs X and her family's wider needs as part of family life. The Ombudsman identified contributory factors including that there was no comprehensive assessment made of Mrs X at her initial admission to A&E, and she was not reviewed by a Consultant for 11 days as no leave cover was in place.

The Ombudsman found that the time taken to investigate and respond to Mr Y's concern (17 months) was unacceptable. He upheld this complaint, although did not find that the response had been sent to the wrong address.

The Health Board accepted the conclusions of the report and agreed to implement the Ombudsman's recommendations that it should:

- a) Apologise to Mr Y for the shortcomings in Mrs X's care
- b) Provide financial redress to Mr Y of £1,000 in recognition of the distress caused by the failure to provide clear management of Mrs X's care
- c) Provide financial redress of £500 in recognition of the time taken to investigate his complaint
- d) Refer the report to the Board, and to the Health Board's Equalities and Human Rights team to identify how consideration of human rights can be further embedded into clinical practice
- e) Remind medical staff on the wards where Mrs X received care of their professional obligations in terms of ethical and clinical management for end of life care in accordance with guidance issued by the General Medical Council

- f) Consider the need for clinicians involved in Mrs X's care to undertake further training in end of life care as part of their continuing professional development
- g) Carry out a clinical audit on the wards where Mrs X received care to consider consistency of medical management and decision making
- h) Remind medical staff of the requirement to ensure adequate cover arrangements are put in place when taking leave.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case number 201605326 – Report issued in September 2017

Ms C complained about the care her father, Mr D, received when he was admitted to Ysbyty Gwynedd. Ms C complained that Mr D's cause of death had not been accurately recorded. Ms C also complained about the way her complaint was handled and the length of time taken to provide her with a response.

The Ombudsman found that the care and treatment provided to Mr D was not of a reasonable standard. Betsi Cadwaladr University Health Board ("the Health Board") did not adequately monitor Mr D's condition and missed a number of opportunities to escalate his care. Had Mr D's care been appropriately escalated his death may have been avoided.

The Ombudsman found that the form submitted to the Coroner by the Health Board did not accurately reflect the cause of Mr D's death.

The Ombudsman also found that the complaint was poorly handled, the amount of time taken to deal with the complaint was unreasonable and the final response did not contain the Serious Incident Report the Health Board had said it would provide.

The Ombudsman upheld the complaint and recommended that the Health Board:

- a) Undertake a NEWS (National Early Warning Score) audit. This should include a minimum 10% dip sample of the NEWS recorded on the ward in the past three months. If members of staff involved in the recording of NEWS for Mr D are now working in a different area, the audit should also include a sample of their current practice. If anomalies are identified, an action plan should be prepared to put this right.
- b) Share this report with the nursing staff involved in this case. Those members of staff should be given training on NEWS and escalation procedures.
- c) Ensure that there is a robust handover system in place and that all acutely ill patients undergo a daily review by a registrar (or above), including on weekends and holidays.
- d) Share this report with the doctors involved in this case. The doctors should then review the report and medical notes with their appraiser to identify areas where practice could be improved.
- e) Discuss this case with the Coroner and based on that discussion undertake an audit (minimum 10% dip sample) of coroner referral forms for the past three months. If inconsistencies or inaccuracies are identified, an action plan should be prepared to address them, this may include introducing a review system or additional training for doctors preparing the forms.

- f) The Head of Corporate Governance should review the complaint handling in this case. The review should seek to identify what happened to the Serious Incident Report.
- g) Apologise to Ms C and her family for the failings identified in this report. A meeting with the Chief Executive or the Medical and Nursing Director should be offered to Ms C.
- h) Make a payment to Ms C of £10,000 in recognition of the distress and uncertainty caused by the clinical failings identified in this report. This payment is also in recognition of the time and trouble taken in pursuing this complaint, due to the complaint handling failings identified in this report.

UPHELD

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201601916 - Report issued in July 2017

Ms X complained about the care and treatment provided to her late father, Mr Y, by Hywel Dda University Health Board ("the Health Board") at Prince Phillip Hospital prior to his diagnosis of lung cancer. Ms X complained about whether tests and investigations were carried out in a timely manner. She said that she had to chase up appointments with consultants. Ms X complained that Mr Y was not told that he had cancer until his last appointment at the Rapid Access Lung Clinic ("RALC") on 10 April 2015. Ms X also complained about the time taken by the Health Board to respond to her complaint and the failure to respond to later correspondence.

The Ombudsman found that tests and investigations carried out in Mr Y's case were reasonable and appropriate. However, he said that they were not carried out in a timely manner and upheld the complaint. As there was evidence to suggest that Ms X did chase up appointments, the Ombudsman upheld the complaint. The Ombudsman could not be sure from the medical records that it was made clear to Mr Y that there remained a possibility of cancer, despite negative test results. He partially upheld the complaint. The Ombudsman upheld the complaint about complaints handling.

The Ombudsman made recommendations including:

- a) an apology and payment to Ms X and the family
- b) a review of the delays in reaching a diagnosis for Mr Y, and
- c) a reminder to relevant staff of the importance of fully recording discussions about diagnosis and prognosis
- d) that the Health Board review the process of booking patients in to the RALC and consider formalising the process.

The Health Board agreed to implement the recommendations.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201603171 - Report issued in July 2017

Mrs A's complaint centred around the management and care that Betsi Cadwaladr University Health Board's ("the Health Board") Wrexham Maelor Hospital ("the Hospital") provided to her late mother, Mrs B. This followed a diagnosis of bladder cancer in 2014.

The Ombudsman found instances of delay in Mrs B's care, had not materially affected her outcome. He concluded that her overall management and care had been reasonable and did not uphold these parts of Mrs A's complaint.

The Ombudsman found documented evidence of communication with Mrs B, her family and GP. However, in the absence of any evidence that Mrs B had been allocated a Clinical Specialist Nurse ("CSN") key worker he concluded that communication could have been more effective. To that limited extent only he upheld this part of Mrs A's complaint.

Administratively, the Ombudsman found that whilst there was some minor omission around record keeping it was not sufficient to warrant upholding the complaint. The Ombudsman did however find shortcomings around complaint handling and upheld this part of Mrs A's complaint.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs A for the failings identified, and
- b) if it had not already done so it should review the effectiveness and operation of its uro-oncology CSN structure.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201603579 - Report issued in July 2017

Mrs A complained about the care and treatment her late mother ("Mrs Y") received while she was an inpatient at Ysbyty Glan Clwyd ("the Hospital"). Mrs A questioned the appropriateness of carrying out a procedure to examine the pancreas and bile ducts by inserting a bendable-lighted tube (endoscope) given her mother's poor health and curvature of the spine. Mrs A questioned if the risks associated with her mother's poor health were discussed during the consenting process. Mrs A also remained unhappy with aspects of the nursing care her mother received following the procedure, which included the poor administration of pain relief and a failure to monitor nutrition. Mrs A was unhappy with the Health Board's handling of her complaint.

The Ombudsman's investigation concluded that the care provided to Mrs Y was reasonable and appropriate and that had she been left untreated her condition would most likely have deteriorated. This aspect of Mrs A's complaint was not upheld.

The Ombudsman considered that there were some service failings in aspects of the consenting process and to a limited extent only upheld this part of Mrs A's complaint.

In relation to complaint handling, the Ombudsman concluded that whilst the complexity of Mrs Y's case meant that some delay in Betsi Cadwaladr University Health Board ("the Health Board") providing a re-

sponse was inevitable; in this instance the delay was excessive. He upheld this part of Mrs A's complaint.

The Ombudsman recommended that the Health Board apologise to Mrs A for the failings identified by the investigation and in recognition of the poor complaint handling make a payment to her of £250.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201602007 - Report issued in July 2017

Mrs A's complaint concerned the care and management she received in 2013 at Ysbyty Gwynedd when she took the difficult decision to end her second pregnancy after being told that her baby had severe foetal abnormalities. Mrs A complained that the medical and midwifery staff failed to give her information/support to make an informed decision about a medical termination and failed to provide her with post termination support. Mrs A said that her medical records were altered following her complaint to the Health Board. Mrs A also complained about poor complaint handling.

The Ombudsman's investigation concluded that the care and treatment provided to Mrs A was reasonable and appropriate. He also found no evidence that Mrs A's medical records were altered. The Ombudsman did not uphold these aspects of Mrs A's complaint.

The Ombudsman was however critical that there were significant delays in complaint handling. He upheld this aspect of Mrs A's complaint and recommended that the Health Board:

- a) apologise to Mrs A, and
- b) pay her a sum of £250 for poor complaint handling and the distress and inconvenience arising from this.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number 201603811 - Report issued in July 2017

Mrs A complained about the management and care her father, Mr B aged 91, received while an inpatient at the Royal Glamorgan Hospital. Sadly, he died a few days after admission. In addition, Mrs A raised concerns about the lack of dignity shown to Mr B and the family, as the family were not present at the end of his life despite this being requested, and the problems with the return of Mr B's personal possessions, namely a slipper and towels, following his death. Finally, Mrs A complained about the Health Board's handling of her complaint and especially the delays.

Despite some clinical failings, the Ombudsman's investigation concluded that broadly Mr B's management and care was reasonable. This part of Mrs A's complaint was not upheld. The Ombudsman was not able to reach a finding on some parts of Mrs A's complaint, such as Mr B's personal possessions or the way news of Mr B's death was communicated to Mrs A and her family, and the issue of the family being contacted, if Mr B's condition deteriorated, given this was not documented in the medical records. The Ombudsman did uphold Mrs A's concerns about Cwm Taf University Health Board's ("the Health Board") handling of her complaint.

The Ombudsman recommended that:

- a) the Health Board's Chief Executive apologise to Mrs A for the failings identified and,

- b) that the Health Board make a payment of £250 in recognition of the shortcomings in the way that it had handled Mrs A's complaint.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number 201303656 - Report issued in August 2017

Mrs A complained about the care given to her late mother, Mrs B, at Prince Charles Hospital, by Cwm Taf University Health Board ("the Health Board"), during March 2013. The clinical issues raised concerned heart-related medication, cardiology input, International Normalised Ratio ("INR") monitoring, the management of breathing difficulties, catheter use, continence care, nutritional care and ward location. The other matters complained about concerned Mrs A's appointment with one staff member and the conduct of another. Mrs A also expressed concern about the Health Board's response to her complaint.

The Ombudsman did not uphold the medication, catheter, location and conduct-connected parts of Mrs A's complaint. He partly upheld its INR, continence care, nutritional care and complaint handling aspects. He found that the Health Board's monitoring of Mrs B's INR was satisfactory. However, he partly upheld this element of Mrs A's complaint because he considered that the Health Board's inappropriate prescription of clopidogrel¹ was relevant to it. He found that the Health Board's assessment of Mrs B's continence care needs was lacking and that it did not prepare a related care plan for her. He also discovered that it did not nutritionally screen Mrs B, as required. He found that the Health Board did not recognise, when responding to Mrs A's complaint, any of the serious clinical failings that he had identified. He fully upheld those parts of Mrs A's complaint which concerned Mrs B's cardiology input, her breathing difficulties and Mrs A's appointment. He considered that the Health Board took too long to provide cardiology input for Mrs B and that its response to her breathing difficulties was deficient. He found that Mrs A's staff member appointment was unreasonably delayed.

The Ombudsman recommended that the Health Board should:

- a) Write to Mrs A to acknowledge, and apologise for, the failings identified in his report.
- b) Pay Mrs A a nominal sum of £500 in recognition of the ongoing distress associated with the clinical failings identified.
- c) Pay Mrs A a nominal sum of £250 for the distress associated with her pursuing her complaint.
- d) Develop a clinical review mechanism, which aims to ensure that junior doctors are not left with the sole responsibility of caring for acutely unwell patients for long periods.
- e) Formally investigate why staff members did not escalate the Health Board's response to Mrs B's deteriorating condition by involving senior colleagues.
- f) Develop an action plan, which aims to prevent a recurrence of the escalation failings identified, in response to the findings of its escalation investigation.
- g) Satisfy itself that it is able to provide appropriate clinical care for its acutely unwell inpatients at all times.

- h) Explain why it did not follow its own protocol when administering Mrs B's warfarin.
- i) Formally remind all relevant nursing staff members that they must assess the continence care needs of all patients when they are admitted to hospital and that they should formulate a care plan to address any needs identified.
- j) Formally remind all relevant nursing staff members that they must nutritionally screen all patients when they are admitted to hospital.
- k) Share this report with all the Consultants, Doctors and Nurses involved in Mrs B's care during March 2013.

The Health Board agreed to implement these recommendations.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201605528 – Report issued in August 2017

Ms X complained about the care she received in the Accident and Emergency Department ("A&E") at Ysbyty Glan Clywd after falling from her horse. She complained that, due to inadequate examination and investigation, a fracture to her spine was not diagnosed at her initial presentation. Ms X said that the fracture was only identified after she had returned to the Emergency Department two days later. Ms X said she suffered avoidable pain as a result of the failings.

The Ombudsman found that Ms X had not been appropriately assessed. In particular, there had been a failure to consider the circumstances surrounding her fall when assessing her possible injuries. He also found that inadequate pain relief was provided following her initial visit. The Ombudsman therefore upheld the complaint and recommended that the Health Board should apologise to Ms X and remind A&E clinicians of the importance of considering the mechanism of injury when assessing trauma patients.

Aneurin Bevan University Health Board – Clinical treatment outside hospital

Case Number 201504573 – Report issued in August 2017

Mr A, whose complex condition includes severe obsessive compulsive disorder ("OCD"), complained about the management and care he received from the Community Mental Health Team ("CMHT") of Aneurin Bevan University Health Board ("the Health Board"). Mr A also raised concerns that his medical records had not been properly read leading to misunderstandings about his treatment and inappropriate medication being prescribed. He also referred to shortcomings in the Health Board's response to his complaint.

The Ombudsman found the management and care that Mr A received from the CMHT was broadly reasonable – though he identified shortcomings in the handover process, when Mr A was assigned a new Care Co-ordinator, and aspects of communication. To that limited extent this part of Mr A's complaint was upheld.

The Ombudsman made no finding on the issues that Mr A raised about his medical records.

Administratively, the Ombudsman identified that the Health Board's complaint response could have been more robust and upheld this part of Mr A's complaint.

The Ombudsman's recommendations to the Health Board included apologising to Mr A, making a payment

of £500 and re-affirming to Mr A the offer to carry out a re-assessment of his needs.

A GP Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital Case Number 201604084 – Report issued in August 2017

Mrs B complained about the standard of care provided to her two year old daughter, C, by her GP. In particular, she complained that the GP continued to prescribe antibiotics for a lump on C's neck for a period of several months with no improvement, and without making a referral for specialist review. C subsequently underwent surgery to have the lump removed.

The Ombudsman found that infected neck glands in young children were relatively common and it was reasonable for the GP to manage this in primary care with antibiotic treatment. The GP had also referred C for an initial paediatric review at the hospital. The situation did not improve after several months of treatment and the abscess started to discharge. At this point, the Ombudsman found that the GP should have referred C for a specialist paediatric view. However, the GP continued to prescribe antibiotics for two further months before agreeing to refer C. This was not reasonable and a much earlier referral should have been made. At hospital, it was found that C had atypical non-tuberculous mycobacterial infection.

The treatment options would not have been any different even if the earlier referral had happened; however, C had taken antibiotic medication for longer than was necessary. The Ombudsman upheld the complaint. The GP Practice agreed to apologise in writing to Mrs B for not referring C earlier.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital Case Number 201603898 – Report issued in August 2017

Mr A complained about the standard of clinical care provided to his late wife, Mrs A, at Ysbyty Gwynedd. He was concerned that investigations to diagnose her bowel cancer, and consequently the start of her treatment, had been delayed.

The Ombudsman found that Betsi Cadwaladr University Health Board ("the Health Board") had properly prioritised Mrs A's investigations. She was placed on the USC (urgent suspected cancer) list for both gynaecology and colorectal teams in July 2013. It was regrettable that she rescheduled several CT scan appointments as she was not well enough to attend. She was also seen by the consultant in August. However, a CT scan, from which the cancer was diagnosed, was not performed until she was admitted to hospital in September 2013. The Ombudsman was concerned that a patient who was on the USC list with two specialties was not chased up for outstanding investigations in the intervening period. There did not appear to have been communication between the two teams with the potential for patients to become 'lost' within the system when they required investigations under two or more specialties.

The Ombudsman upheld the complaint. He recommended that the Health Board should provide a written apology to Mr A, and should review the operation of its pathway to track USC referrals that may potentially fall under the care of two specialties.

A GP Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital Case Number 201604084 – Report issued in August 2017

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The Ombudsman upheld the complaint. The GP Practice agreed to apologise in writing to Mrs B for not referring C earlier.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number: 201603674 – Report issued in August 2017

Mr A complained about the standard of care and treatment provided to his late wife. Mrs A had neuroendocrine tumours ("NETs"). Mr A was particularly concerned that there were inconsistencies in the care provided, delays in implementing somatostatin analogue therapy and that Mrs A was not referred to a specialist NET centre in England.

In considering the complaint, the Ombudsman noted that the state of knowledge about the treatment of NETs had progressed since Mrs A was receiving treatment. The Ombudsman upheld the complaint about potential inconsistencies in care to the extent that communication about Mrs A's care within the clinical team and with Mr and Mrs A could have been better. He did not uphold the complaint about delay in implementing somatostatin analogue therapy, as whilst this could have been started sooner, it was sadly unlikely in the particular circumstances to have prevented Mrs A's disease progressing. Finally, the Ombudsman upheld the complaint about the referral to a different hospital to the extent that there was a reporting error in a CT scan which, if it had not happened, may have prompted an earlier discussion about Mrs A's suitability for a trial of a particular treatment at the other hospital.

The Ombudsman recommended that Cardiff and Vale University Health Board:

- a) apologise to Mr A for failings identified
- b) review why there was a reporting error in the CT scan, and
- c) review the adequacy of communications within its NETs service.

Cardiff and Vale University Health Board – Medical records / standards of record keeping

Case Number 201604214 – Report issued in August 2017

Mrs A's complaint concerned the care her mother, Mrs R, received while an inpatient at the University Hospital Llandough ("the Hospital"). Mrs A's concerns included nursing staff not providing encouragement or assistance to her mother to enable her to eat her meals. She also questioned whether her mother's food intake records had been 'falsified'. In addition, she complained that her mother had developed a rash because her continence pads were not changed frequently.

The Ombudsman's investigation concluded that aspects of Mrs R's nursing care were broadly reasonable and tailored to her needs. However, he identified instances where Mrs R's care fell below reasonable standards, for example, the delay in providing Mrs R with a pressure relieving mattress. The Ombudsman upheld Mrs A's complaint to a limited extent.

Administratively, the Ombudsman was concerned that inadequate record keeping meant that it was not always possible to comment on the quality of nursing care delivered to Mrs R. To that extent he upheld this aspect Mrs A's complaint.

The Ombudsman recommended that Cardiff and Vale University Health Board:

- a) provide a written apology to Mrs A for the failings the investigation had identified
- b) make a payment of £350 to her in recognition of the distress caused to her as a result of poor record keeping, and
- c) provide details of the measures it had put in place to address the failings.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201606212 – Report issued in August 2017

Mrs A complained to the Ombudsman about the manner in which Betsi Cadwaladr University Health Board ("the Health Board") had failed to give her a follow up appointment to monitor her deteriorating eye condition in a timely manner. Instead of being given a follow-up appointment within six months as stipulated by her clinicians, Mrs A was not reviewed for 13 months, despite Mrs A requesting an urgent appointment. By the time Mrs A was seen in the ophthalmology clinic, the vision in her right eye had been irreparably lost (although it was recognised that this would eventually be the outcome). Mrs A argued that if she had been seen earlier then the damage to her eye could have been treated thereby preventing the rapid deterioration of her right eye.

The Ombudsman found that the Health Board had failed to provide Mrs A with an adequate level of service and that if she had been reviewed appropriately there was a much greater likelihood that she would have received more timely treatment. Such treatment could potentially have slowed the deterioration of her condition.

The Ombudsman upheld the complaint and recommended that the Health Board:

- a) apologise to Mrs A and provide her with redress of £2,000 for the possibility that if she had been reviewed earlier she would have retained the vision in her right eye for longer, and
- b) put measures in place to ensure that when patients such as Mrs A requiring urgent intervention approach the Health Board, they are seen within 24 hours

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201604112 – Report issued in August 2017

Mrs T complained about the care and treatment her late father-in-law, Mr X, received at Nevill Hall Hospital ("the Hospital"). In particular, Mrs T was concerned that Mr X was not well enough to have been discharged on 4 March 2016 and that the care and treatment provided upon his readmission on 6 March was not appropriate.

The Ombudsman found that it was clinically reasonable for Mr X to have been discharged from the Hospital on 4 March and did not uphold this element of the complaint.

In considering Mrs T's concern about the treatment provided to Mr X upon his re-admission, the Ombudsman found that there were delays in diagnosing and treating Mr X for sepsis. The Ombudsman was of the view that Mr X's clinical deterioration was not recognised in time and appropriate action was not taken. Aneurin Bevan University Health Board ("the Health Board") had a policy in place to deal with the escalation of deteriorating patients, but the Ombudsman found that this policy had not been followed. This element of Mrs T's complaint was upheld.

It was recommended that the Health Board:

- a) provide a written apology to Mrs T and her family for the failings identified in this report.
- b) pay Mrs T on behalf of the family £500 to reflect the uncertainty of not knowing whether, if treatment had been initiated sooner on 6 March, and a referral to the ITU made during the morning of 7 March, the outcome may have been different.
- c) raise awareness of the Deteriorating Patient Policy amongst the staff nurse and clinical staff concerned at the ED.
- d) reviews the management of sepsis at the Hospital's ED and takes action to remind staff of the need to follow guidelines.

The Health Board agreed to implement these recommendations.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number 201604041 - Report issued in September 2017

Ms X complained about the poor management of her ectopic pregnancy at the Royal Glamorgan Hospital ("the Hospital") and, specifically, delay in diagnosing and addressing that issue. She was aggrieved that the delay led to a ruptured fallopian tube and an inability to conceive naturally (because this was the second time she suffered this particular event). She also complained that the pain she was suffering from was not managed adequately. She said that, on one occasion, she was left for almost two hours bleeding heavily and screaming in pain in a store room and that she was refused pain relief.

The investigation found that the management of Ms X's condition had generally been reasonable and appropriate. However, clinicians failed to offer Ms X the option of surgical intervention to address the ectopic pregnancy. The complaint was, therefore, upheld to that limited extent. The investigation found that Ms X's pain had not been managed properly on the occasion referred to above for approximately an hour and a half. That complaint was also upheld.

Cwm Taf University Health Board agreed to:

- a) apologise to Ms X for the failings found by the investigation
- b) to offer a payment of £150 for the unmanaged pain, and
- c) to share the findings of the report with relevant staff.

Hywel Dda University Health Board - Clinical treatment in hospital Case Number 201604278 - Report issued in September 2017

Mr Y complained about the failure to promptly diagnose and treat the sepsis from which he suffered during an admission to Worthybush General Hospital. Mr Y also complained about a delay in diagnosing a tear in his oesophagus. Finally, Mr Y complained about the way in which the Health Board had handled and responded to his formal complaint.

The Ombudsman concluded that, whilst there were some failings in respect of the monitoring of Mr Y's condition during his admission, the treatment overall was adequate. The Ombudsman also found that the oesophageal tear was a rare condition, the diagnosis of which was not unreasonably delayed. The Ombudsman was, however, critical of Hywel Dda University Health Board's complaint handling and recommended that they:

- a) make an apology
- b) and pay Mr Y £500 financial redress, in recognition of the time and trouble to which he had been put in pursuing his complaint.

Cwm Taf University Health Board - Clinical treatment outside hospital Case Number 201602370 - Report issued in September 2017

Mr H complained about a failure to maintain or improve his mother, Mrs B's, mobility during her care and that investigations for urine infections were unnecessary and distressing. Mr H also raised dignity and autonomy concerns relating to her capacity, cognition, deprivation of liberty safeguards, Mrs B's wishes to be discharged and being strapped to a trolley during an appointment. Additionally, Mr H complained about Cwm Taf University Health Board's ("the Health Board") communication with Mrs B and the family about her care and subsequently that it had failed to notify him of her death. Mr H later complained to the Health Board, but was unhappy with its delay in responding.

The investigation found that the care given to Mrs B was reasonable and appropriate steps were taken to address her mobility. The investigation also found that urine investigations were necessary and did not distress her. There were no shortcomings in Mrs B's care in relation to dignity and autonomy concerns. These complaints were not upheld.

Mr H's concern about complaint handling was upheld because of the time and trouble that he encountered in pursuing the complaint. The Health Board mistakenly told Mr H it could not reply because prior to Mrs B's death she had not consented to him raising a complaint. The Ombudsman recommended:

- a) an apology

- b) nominal financial redress in recognition of the delay; and
- c) internal procedural review.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201604109 - Report issued in September 2017

Dr X complained that his late brother Mr Y's urgent GP referral to the rapid access chest pain clinic ("RACPC") at Ysbyty Gwynedd was not acted upon in a timely manner on 10 July 2016. Mr Y received a letter inviting him to make an appointment with the RACPC on 21 July. Sadly Mr Y died on 20 July, his cause of death was due to ischaemic heart disease.

The Ombudsman found that Mr Y should have been triaged earlier than seven days after the GP's urgent referral and despite the Consultant identifying Mr Y's abnormal ECG reading and suggesting that the GP should have referred Mr Y as an emergency, a letter to arrange an appointment was only sent 12 days after referral. The Ombudsman also found that it was unacceptable that Dr X waited four months for a meaningful response from the Health Board. The Health Board agreed to implement the Ombudsman's recommendations to:

- a) apologise to Dr X and Ms Y (Mr Y's partner) that Mr Y was not triaged within 24 hours and it had not responded to Dr X's email in a timely manner
- b) review the percentage of RACPC referrals not triaged within 24 hours or the next working day, whether there needs to be a modification of job plans or the numbers of cardiologists to deliver RACPC in a timely manner; and
- c) consider whether it should develop a protocol for GP referrals to RACPC.

A GP Practice within the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital Case Number 201604107 - Report issued in September 2017

Dr X complained about the treatment his late brother Mr Y received from his GP at three appointments between 11 June and 10 July 2015. On 20 July, Mr Y died from ischaemic heart disease. Dr X said that the GP failed to take a proper history from Mr Y and had he been referred to cardiology earlier he may not have died.

The Ombudsman found that the GP's note keeping fell below a reasonable standard, as such he could not conclude whether Mr Y's symptoms were angina or that he should have had an earlier cardiology referral. The Ombudsman found that at Mr Y's 10 July appointment, the GP failed to identify an abnormal ECG and prescribe additional anti angina medication. The Practice agreed to implement the Ombudsman's recommendations to:

- a) apologise for the failings to Dr X and Ms Y (Mr Y's widow)
- b) make a redress payment to Ms Y of £1000
- c) confirm it has a protocol to consistently record medical information
- d) consider a system for health care professional to interpret ECG results, undertakes Information

Governance training

- e) hold a staff meeting to reflect upon the final report; and
- f) that the GP revise the assessment, diagnosis and management of angina, read the NICE guidelines and has training to improve her record keeping.

A Dental Practice in the Betsi Cadwaladr University Health Board area – Clinical treatment outside hospital Case Number 201600835 - Report issued in September 2017

Mrs X complained to the Ombudsman that in September 2015 she attended the Practice with a cracked tooth. An X-ray was taken and the Dentist noted a large filling and radiolucency (shadow) around the end of the root. Mrs X underwent treatment, including antibiotics, until December when the tooth fractured and was extracted. Mrs X also complained about the Practice's handling of the complaint about her treatment.

The Ombudsman could not conclude that an abscess was present at Mrs X's first appointment or that there should have been root canal treatment. The Ombudsman found that the Dentist had not recorded her interpretation of the radiolucency or her intended action in relation to it; this was an injustice to Mrs X. The Ombudsman also found that the Practice had inappropriately absolved itself of responsibility for the complaint and had directed Mrs X to the Dentist, even after the Dentist had left the practice. The Practice agreed to implement the Ombudsman's recommendations to:

- a) apologise to Mrs X for the identified failings
- b) reimburse £185
- c) make a redress payment of £300 as the dentist had not recorded her interpretation of the radiolucency and insufficient action was taken to determine its state; and
- d) make a redress payment of £100 for the fact that Mrs X's complaint was not thoroughly investigated.

NOT UPHELD

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number 201605053 - Report issued in July 2017

Mr B complained about care he received as an inpatient at a Mental Health Unit. He said he had been prescribed medication which he was allergic to, that leave had been withdrawn, Aneurin Bevan University Health Board had refused to change the doctors in charge of his care and he had been subjected to unnecessary searches.

The complaints were not upheld. The investigation found that there was no evidence to suggest that Mr B had an allergic reaction to the medication and that he had been appropriately monitored. It found that leave had been appropriately reviewed and authorised and where there had been issues facilitating leave, these had been addressed. The investigation also found that the decision not to change Mr B's doctors was reasonable and appropriate in the circumstances and that when Mr B refused to submit to a search this issue had not been pressed.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number 201605732 - Report issued in July 2017

Mr X complained that when he attended the Emergency Department of the Royal Glamorgan Hospital following an accident on 17 June 2016, staff failed to identify that he had a number of broken ribs and a pneumothorax. When he re-attended on 19 June, an X-ray was performed and these injuries were identified. Mr X was subsequently managed conservatively with pain relief and no surgical intervention was required. When Mr X complained to Cwm Taf University Health Board ("the Health Board") about the failure to identify the pneumothorax and broken ribs, it acknowledged that Mr X should have received an X-ray and been monitored on 17 June. The Health Board were clear however, that the treatment that would have been provided on 17 June, had the X-ray been taken then, would not have differed from the conservative treatment he received following his second attendance. Mr X was dissatisfied with this explanation and complained to the Ombudsman that the failure to perform the X-ray on 17 June, to identify the pneumothorax and broken ribs, had caused him harm.

The Ombudsman agreed with the Health Board that Mr X should have received an X-ray on 17 June and that if this had happened his injuries would have been identified. The Ombudsman also agreed that it would have been appropriate to manage Mr X's condition conservatively with monitoring and pain relief. The conservative management Mr X subsequently received on his admission on 19 June reflected this approach. Accordingly the Ombudsman found that there was no injustice to Mr X as a result of the Health Board's failure to identify the broken ribs and pneumothorax and did not uphold the complaint.

A Dental Practice in the area of Hywel Dda University Health Board

Mrs A complained about the care and treatment she received from the Dental Practice. Specifically, Mrs A said that, during an appointment on 22 July 2016, the Dentist failed to identify and treat an abscess in her gum, leaving her in pain and resulting in subsequent hospital treatment.

The investigation found that Mrs A's treatment plan was reasonable in the circumstances and, given the absence of infection at that time, it had been reasonable not to prescribe antibiotics.

Hywel Dda University Health Board and an Independent Provider contracted by Hywel Dda Health Board

Case Number 201606182 / 201505518 - Report issued in July 2017

Mrs T complained to the Ombudsman about the care and treatment that her granddaughter, Ms G, received at an Independent Provider contracted by Hywel Dda University Health Board ("the Health Board") (a low secure, adult psychiatric hospital in Wales). Mrs T also complained that the Health Board transferred Ms G to a medium secure unit in England against the wishes of the family and against the advice of senior clinicians. Specifically, Mrs T complained that:

- Ms G's condition of anorexia nervosa was not adequately managed by clinicians at the Hospital.
- For more than a year Ms G lived in isolation in a sparse environment and was subject to a range of punitive restrictions on movement and activity.
- Ms G was deprived of her belongings and a number of her possessions were lost during her stay at the Hospital.
- The family was excluded from any meaningful participation in Ms G's care and their views about her

care were dismissed and even resented by clinicians.

- Ms G's medication regime was poorly managed.

The Ombudsman did not uphold Mrs T's complaints. He concluded that the approach to Ms G's care and the restrictions and controls placed on her environment were appropriate to the severity of her condition and to the risks she posed to herself and others. He was unable to identify any evidence that the family was excluded from participating in Ms G's care or that her medication regime was poorly managed. Finally, he concluded that, given all of the circumstances, the Health Board's decision to transfer Ms G to a medium secure unit in England was reasonable.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201604061 - Report issued in July 2017

Ms X complained that Cwm Taf University Health Board failed to perform her knee replacement surgery appropriately. Ms X said that the surgeon had incorrectly cut through her muscle during surgery and consequently she experienced an extended period of pain and post operative knee problems.

The investigation found that Ms X's surgery was performed appropriately. There was no evidence to suggest that her muscle was incorrectly or accidentally cut because a knee brace would have been required straight away, which was not part of Ms X immediate post operative care plan. The investigation also found that unfortunately continuing significant symptoms are not uncommon and in this case was not suggestive of poor care. The Ombudsman did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital

Case Number 201602270 - Report issued in July 2017

Ms A complained about the poor care provided to Mrs B by Abertawe Bro Morgannwg University Health Board's ("the Health Board") Rapid Access Clinic for Eyes ("RACE"). She specifically complained that the Health Board failed to properly record Mrs B's allergic reaction to eye drops instilled on 23 June 2015, and as a result Mrs B had the same drops instilled on 5 August which resulted in a further allergic reaction. Ms A complained that Mrs B's allergic reactions caused her to develop photophobia and dry eyes and she considered this led to Mrs B's premature death because she fell four days later, and died from the head injury sustained by that fall. Also Ms A complained that Mrs B was given insufficient eye medication (sample bottles) to treat her eye condition.

Ms A's complaints were not upheld. The investigation found that the eye drops administered on 23 June and 5 August for pupil dilation were appropriate. Mrs B's reaction after the drops used in June was recorded by the Health Board at her next appointment in August. Mrs B received appropriate treatment following her reaction in August and when reviewed a week later it was noted that Mrs B's eyes had improved following the treatment. Mrs B's photophobia documented on two occasions in September was most likely to have resulted from her other subsequent diagnosed eye conditions. In relation to the insufficient eye medication complaint, it was not possible to reach a definitive view as the investigation was almost two years after the event. Whilst both the Health Board's and Ms A's comments were duly considered, the Ombudsman considered the Health Board had taken appropriate actions, following Ms A's complaint, to address any potential concerns in this regard.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201605144 - Report issued in July 2017

Mr D complained about the standard of care provided to his late wife, Mrs D, at Prince Charles Hospital. His complaints were that:

- a) Rivaroxaban (an anti-coagulant medication) was stopped after six months treatment without further assessment or re-scanning. Mrs D suffered a stroke several weeks later;
- b) There was insufficient investigation into the cause of the discolouration of Mrs D's hand;
- c) Mrs D was discharged from hospital when she was clearly very unwell and when clinicians still had not reached a diagnosis concerning the discoloration of her hand.

The Ombudsman found that the treatment provided to Mrs D was appropriate and in line with current practice guidelines. There was no indication for re-scanning Mrs D after stopping Rivaroxaban medication. The investigations done into the discolouration of Mrs D's hand and the decision to discharge her from hospital were both reasonable. The Ombudsman did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201604370 – Report issued in August 2017

Ms X complained about the treatment provided to her late mother, Mrs A at the Princess of Wales Hospital following her admission in December 2015 after she suffered a stroke. In particular, Ms X complained that it was inappropriate for the anticoagulant drug Apixaban to have been administered to Mrs A and that there was an unreasonable delay in her receiving treatment after she suffered a brain haemorrhage. Ms X also complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to respond to a letter of complaint of 5 May 2016 in respect of missing observations charts.

The Ombudsman found that there was no evidence to suggest that it was inappropriate for Mrs A to have received the anticoagulant drug Apixaban. He considered that the treatment provided following Mrs A's brain haemorrhage was timely and appropriate. Finally, the Ombudsman found that it was unclear whether the Health Board had received a letter of complaint of 5 May 2016 in respect of missing observation charts; however there was evidence of correspondence to Ms X in which the Health Board acknowledged that it was unacceptable that they were missing, and offered a sincere apology for this. The Ombudsman did not uphold any aspects of the complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201603825 – Report issued in August 2017

Mr D complained to the Ombudsman that Betsi Cadwaladr University Health Board ("the Health Board") had failed to identify, despite having performed an ultrasound scan, that his wife ("Mrs D") had a large fibroid mass when she attended Ysbyty Glan Clwyd ("the Hospital"). He was aggrieved that when Mrs D had been discharged, the doctor had failed to note in his discharge note that she was anaemic. It was a few days later that Mrs D, following a private consultation and investigations abroad, found out that she had an abdominal mass which turned out, upon being operated upon a few months later to be a fibroid lesion that had died. Mr D considered that if the scan that was performed in the Hospital had identified the lesion and his wife's blood test result had been identified correctly, the subsequent management of her treatment

would have been more timely.

The Ombudsman found that while the scan had failed to identify the fibroid, this was a common shortcoming of this particular procedure, which did result in certain gynaecological features being missed. Therefore, the Ombudsman concluded that this did not amount to a service failure. The Ombudsman also found that, while the discharging doctor did not include the correct information about Mrs D's anaemia within the discharge note, this did not result in an injustice to Mrs D since she was given appropriate medication to treat the anaemia when she was discharged. Accordingly, the complaints were not upheld.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number 201606532 – Report issued in August 2017

Mr B complained about the care his wife received at Prince Charles Hospital during labour. He complained that there was an unnecessary delay in inducing labour, followed by a failure to properly monitor, interpret and react to his unborn child's heartbeat. Mr B said that these failures resulted in his daughter suffering cardiac problems soon after birth.

The Ombudsman found that there was no adverse clinical significance to the delay in inducing labour, adequate monitoring was carried out and appropriate clinical reviews and tests were undertaken. The Ombudsman concluded that there was no evidence to suggest that the problems Mr B's daughter experienced were due to any shortcomings in the care provided during labour. The Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number 201606156 – Report issued in August 2017

Mr B complained about the decision to discharge him from the Emergency Department of the University Hospital of Wales following a seizure earlier the same day. He complained that the discharge was premature and did not properly take into account his head injury and family history. Mr B also complained that a shoulder injury was missed and he was not given anti-seizure medication prior to discharge. Mr B suffered a further seizure on his journey home from the hospital.

The Ombudsman found that Mr B was appropriately examined and treated and that his discharge was appropriate. He concluded that all relevant factors were considered in reaching the decision to discharge and that it would not have been appropriate to prescribe anti-seizure medication before a definitive diagnosis had been reached following further outpatient investigations. The Ombudsman said that the presence of the shoulder abnormality on the X-ray was subtle and easily missed until reviewed by a specialist consultant. The Ombudsman did not uphold the complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number 201604020 – Report issued in August 2017

Ms E complained that adjustments had not been made when a gynaecological procedure was carried out at Nevill Hall Hospital. Ms E said that she had provided relevant information to the referring clinician. As a result, Ms E had concerns about the consenting process.

As the Ombudsman found no service failings this part of Ms E's complaint was not upheld. He also found

no grounds to question the validity of the consent obtained from Ms E and again did not uphold this aspect of her complaint.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital **Case Number 201603289 – Report issued in August 2017**

Ms X complained about the care she received from Betsi Cadwaladr University Health Board

("the Health Board") during her pregnancy, which, very sadly, resulted in Ms X's son, Y, being stillborn. She also complained about the failure of the Health Board to provide her with counselling following this, and about the Health Board's response to her complaint.

The Ombudsman found that Ms X's care throughout her pregnancy was generally reasonable, with appropriate monitoring and involvement of the Consultant and other members of the team. Any shortcomings identified did not impact on Ms X's care. Y's death could not reasonably have been predicted, and the Ombudsman did not uphold the complaint. He urged the Health Board to be more careful to ensure the accuracy of complaint responses in future, and suggested that the Health Board, even at this late stage, arrange counselling for Ms X if she wished it. The Health Board agreed to meet Ms X to discuss making a referral for counselling for her.

Velindre NHS Trust - Clinical treatment outside hospital **Case Number 201605282 – Report issued in September 2017**

Dr D complained that there was a delay in diagnosing her late father's metastatic spinal cord compression ("MSCC"), a relatively rare complication which can occur in patients with cancer which has spread to the bones in their spine. If not treated, it can cause permanent paralysis. She complained that Velindre NHS Trust ("the Trust") should have acted more quickly when Mr D began complaining of back pain in January 2015. She also complained that the Trust should have explained to Mr D and his family about the potential for him to develop MSCC, so they could have been alert to the potential symptoms.

The Ombudsman found that, on balance, it was more likely than not that Mr D was not given information about MSCC when he was told the cancer had spread to his spine. However, this did not affect the outcome as in the event Mr D's paralysis was not due to any delay in MSCC being diagnosed. He therefore did not uphold this part of the complaint. The Ombudsman also did not uphold the complaint that the Trust should have acted more quickly when Mr D complained of back pain. When Mr D rang its advice line, he was appropriately referred to his GP in line with standard practice.

Aneurin Bevan University Health Board - Clinical treatment in hospital **Case Number 201605059 - Report issued in September 2017**

Mr X raised concerns that a wound on his five month old grandson's ("B's") neck was not thoroughly checked when he was taken to hospital on 11 March 2015. When they returned to the hospital on 15 March, the wound was infected, which caused B to require surgery to treat the infection.

The Ombudsman found that the clinical assessment of B on 11 March was reasonable and there was no evidence to indicate that an infection was present during this attendance or that antibiotics should have been

prescribed. The Ombudsman did not uphold the complaint.

Betsi Cadwaladr University Health Board - Other Case Number 201605583 - Report issued in September 2017

Mr A complained about the treatment he received following his diagnosis of Multiple Sclerosis (“MS”) a neurological lifelong condition that affects the nerves in the brain and spinal cord). Mr A said that he was denied timely and effective treatment to control the symptoms and progression of MS. Mr A also raised concerns that he had been denied access to alternative therapy that may have improved his quality of life.

The Ombudsman found that Mr A received treatment relevant to his presenting symptoms and that the management of his condition was entirely appropriate. There were no failings in the timeliness, management or treatment of Mr A's condition. The Ombudsman did not identify evidence of any additional treatment that could have been provided to Mr A as there are no alternative therapy treatments licensed for progressive MS, either primary or progressive. Consequently the complaints were not upheld.

Betsi Cadwaladr University Health Board - Other Case Number 201604252 - Report issued in September 2017

Mrs X complained that Betsi Cadwaladr University Health Board (“the Health Board”) failed to treat her mother, Mrs Y, within the Welsh Government's referral to treatment time (“RTT”) target for NHS organisations in Wales.

The investigation found that, although the time that Mrs Y had been waiting for her operation had exceeded the Welsh Government's RTT target, there was no evidence that this could be attributed to mismanagement of the waiting list by the Health Board. There was no evidence to suggest that Mrs Y met the Health Board's criteria for expedited treatment and no indication of a clinical need, which would justify expediting her treatment ahead of others.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number 201606340 - Report issued in September 2017

Mr X complained about the care he received during an appointment at the University Hospital of Wales in February 2016. He complained that a Consultant failed to correctly diagnose the cause of his persistent hoarse voice which he said was subsequently diagnosed and successfully treated following a private consultation.

The Ombudsman found that the care at the appointment did not fall below an acceptable standard. He did not uphold the complaint.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital Case Number 201600691 - Report issued in September 2017

Mr A complained that Betsi Cadwaladr University Health Board (“the Health Board”) had failed to adequately investigate and treat his daughter's gait problem from January 2015 onwards.

The Ombudsman found that there was evidence that appropriate investigations had been carried out into Miss A's gait problem and, where necessary, appropriate actions taken in response. He did not uphold the

complaint.

A GP Practice in the Aneurin Bevan University Health Board area – Clinical treatment outside hospital Case Number 201605281 - Report issued in September 2017

Dr D complained that there was a delay in diagnosing her late father's metastatic spinal cord compression ("MSCC"), a relatively rare complication which can occur in patients with cancer which has spread to the bones in their spine. If not treated, it can cause permanent paralysis. Dr D complained that Mr D's GP Practice should have acted more quickly when he began complaining of back pain in January 2015.

Mr D attended the Practice on three occasions in January 2015. The Ombudsman found that whilst in hindsight it was possible that Mr D was displaying early symptoms of MSCC at these consultations, he also had other symptoms which suggested alternative, more likely, diagnoses. The symptoms at each consultation did not clearly suggest MSCC, and the Ombudsman concluded that the GPs' actions were in line with reasonable clinical practice. He did not uphold the complaint. The Ombudsman did note, however, that there was a learning point from the case, in relation to the need to adequately discuss the symptoms of MSCC with patients who are at risk of developing it and, where appropriate, their families.

EARLY RESOLUTION

Cardiff and Vale University Health Board – Clinical treatment outside hospital Case Number 201701455 - Report issued in July 2017

Mr B complained that he waited an excessive amount of time to be seen by a dermatologist following referral by his GP for suspected skin cancer. The dermatologist failed to biopsy the lesion and categorised him as a routine case. Mr B said he should have been categorised as urgent and should not have waited 20 months from referral to treatment.

Cardiff and Vale University Health Board ("the Health Board") said it acknowledged that there had been a breach of duty of care relating to Mr B's wait for surgery; it agreed to instruct an Independent Expert to advise whether any harm could have been avoided, had there not been a delay in undertaking Mr B's surgery. The Health Board agreed to conclude this matter and respond to Mr B within three months. The Ombudsman was satisfied that this action would resolve the complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201701103 - Report issued in July 2017

Mrs X complained about the care and treatment provided to her husband Mr X when he was admitted to hospital in November 2016. She complained that the Hospital failed to administer prescribed medication and, when he was discharged, he was issued with a large amount of incorrect medication.

Mrs X felt Aneurin Bevan University Health Board ("the Health Board") had not understood her concerns. She was also concerned that she had not received the outcome of an investigation into the issuing of the incorrect medication. Mrs X said that she felt she could no longer trust the Hospital to care for her husband.

The Health Board agreed to arrange for Mrs X to meet with relevant staff to discuss her complaint, as well

as the outcome of the pharmacy investigation into the issuing of the incorrect medication to Mr X. The Ombudsman was satisfied that this was reasonable action which would settle the complaint.

Cardiff and Vale University Health Board – Continuing Care Case Number 201700901 - Report issued in July 2017

Ms A complained that Cardiff and Vale University Health Board (“the Health Board”) had failed to respond to her letter of January 2017, in which she had raised concerns about an outstanding assessment for NHS continuing health care funding. She also presented new concerns relating to the assessment and care plan that the Health Board had not yet had the opportunity to consider.

The Ombudsman noted that there had been a delay in responding to the complainant. Whilst normally the Ombudsman would expect the Health Board to have been given the opportunity to deal with the new concerns before coming to him, in light of the delay already experienced with the existing complaint the Ombudsman sought some assurances from the Health Board. The Health Board agreed that it would respond to the new concerns raised in the complaint made to the Ombudsman.

In settlement of Ms A’s complaint regarding her letter of January 2017 the Health Board agreed to:

- a) provide a written response to the outstanding complaint letter and,
- b) provide an apology for the delay within four weeks of this decision.

Cardiff and Vale University Health Board – Continuing Care Case Number 201604681 - Report issued in July 2017

Mr A’s Solicitors complained on his behalf about deficiencies in the way Cardiff and Vale University Health Board (“the Health Board”) carried out the NHS Funded Continuing Care (“NHSFCC”) process. The Solicitors complained about the Health Board’s refusal to allow an appeal to an Independent Review Panel (“IRP”) for it to consider whether Mr A’s late father in law, Mr M, was eligible for retrospective NHSFCC. The Solicitors also had concerns that the Health Board’s decision letter failed to properly explain its decision and made no mention of its complaints procedure.

The Ombudsman’s investigation established that there had been shortcomings in the NHSFCC process. As a result the Health Board agreed to settle the complaint on the following terms:

- a) The Health Board would complete a new Needs Assessment to determine whether Mr M was eligible for retrospective NHSFCC.
- b) The Health Board would ensure that when cases were peer reviewed, the date and the peer reviewer’s signature was documented on the Needs Assessment.
- c) In cases where no eligibility was found, and the decision was taken not to hold an IRP, the Health Board would provide the family and their representatives with a full written explanation of the rationale behind the decision. This would include why that decision was made, and an explanation setting out why the needs of the individual fell outside of the eligibility criteria.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201701276 - Report issued in July 2017

Mr A contacted the Ombudsman to complain about the standard of care and treatment he had received from Betsi Cadwaladr University Health Board ("the Health Board") for an existing health problem. The central aspect of the complaint concerned difficulties in arranging diagnostic appointments.

The Ombudsman contacted the Health Board who agreed to undertake the following action as resolution to Mr A's complaint:

- a) To contact Mr A to make the necessary arrangements for further clinical tests.

Betsi Cadwaladr University Health Board – De-registration

Case Number 201701979 - Report issued in July 2017

Ms H complained that she had not received a response to her complaint, which was raised with the Health Board on 8 March 2017. The substance of the complaint related to Ms H's GP Surgery, which Betsi Cadwaladr University Health Board ("the Health Board") decided to investigate itself. However, despite receiving assurance in April 2017 that the investigation was "almost complete" no response had been forthcoming.

The Ombudsman found that whilst the Health Board may have had some difficulty in progressing the concern owing to staffing issues, the length of time it has taken for the Health Board to provide a response is excessive. Furthermore, it seemed that the email which advised a response was "almost complete" was misleading and did not manage Ms H's expectations reasonably or realistically.

The Health Board agreed to expedite its investigation and undertake the following actions in settlement of the complaint:

- a) Apologise for the delays in providing a response; and
- b) Ensure that the complaint response is issued by 31 July 2017.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201701191 - Report issued in July 2017

Mr E complained about the care and treatment that his wife received during an endoscopy procedure at Wrexham Maelor Hospital in August 2016. Mr E said that he was dissatisfied with Betsi Cadwaladr University Health Board's ("the Health Board") response to his complaint. Mr E therefore asked the Ombudsman to consider his outstanding issues relating to monitoring his wife's vital signs and pain, communication any discomfort she may experience.

Following consideration of the complaint, the Investigating Officer saw no evidence to suggest that the outstanding issues raised with the Ombudsman had previously been brought to the attention of the Health Board. Therefore, the Investigating Officer was of the view that it would be beneficial to Mr E to discuss the outstanding issues with the Health Board in the first instance. The Investigating Officer contacted the Health Board to discuss the matter.

The Health Board agreed to contact Mr E within three weeks of the Ombudsman's decision being issued, to arrange a meeting to discuss the outstanding issues.

The Health Board agreed to do so in settlement of the complaint.

Powys Teaching Health Board – Clinical treatment in hospital Case Number 201701594 - Report issued in July 2017

Mrs D complained that the Board had failed to provide adequate Mental Health care and treatment for her late mother during 2015. She felt that community psychiatric nurse was generally disinterested in her mother's condition and encouraged her to move into a care home when her family considered that she could have remained at home. The complainant's mother sadly passed away on 23 May 2016.

She also complained that the Board had failed to organise a local resolution meeting that it offered her in its complaint response letter dated 4 January 2016.

The Ombudsman considered that it was unable to investigate the matters complained of that occurred in 2015 due to the lapse in time. It did, however, contact the Board in relation to the promised local resolution meeting.

The Board agreed to resolve the complaint voluntarily by arranging a meeting with the complainant within 20 working days of the date of this summary.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201701778 - Report issued in July 2017

Mrs H complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") had failed to diagnose and treat her son who had symptoms similar to Chronic Fatigue Syndrome and Myalgic Encephalomyelitis.

The Ombudsman considered the information available and decided that an investigation would be unlikely to achieve anything further for the complainant. He did, however, contact the Board and it agreed to:

- 1) Arrange a meeting with her (and her son, if appropriate) in order to discuss her concerns, and
- 2) Provide an action plan in order to diagnose/manage his illness. The action plan will include details of the appropriate person to take any action forward i.e. Board staff member/department or parent.

The meeting should be arranged within 20 working days of the date of this summary and an action plan provided to her within 10 working days of the meeting.

The Ombudsman considered that the actions promised by the Board were reasonable.

Cwm Taf University Health Board – Continuing Care Case Number 201700989 - Report issued in July 2017

Mr A's solicitor complained on his behalf about the decisions of Cwm Taf University Health Board ("the Health Board") not to award NHS continuing healthcare funding for his mother, Mrs A. The solicitor said that in respect of a claim during 2014 to 2015, the Health Board marginalised Mrs A's needs. The solicitor also said that the Health Board failed to take on board the information they submitted for an appeal against the 2016 decision because it did not notify them at the relevant time, instead corresponding directly with Mr A.

The Health Board agreed to take the following actions to resolve the complaint:

- a) Hold an Independent Review Panel into the decision not to award continuing healthcare funding between 2014 and 2015.
- b) Hold an Independent Review Panel into the decision not to award continuing healthcare funding in 2016.

Cardiff and Vale University Health Board – Continuing Care Case Number 201701350 - Report issued in July 2017

Mr B's solicitor complained on his behalf about the decision of Cardiff and Vale University Health Board ("the Health Board") not to award NHS continuing healthcare funding for his father, Mr C. The solicitor said that in respect of a claim for 2016, which followed an assessment completed on 14 December 2016, the Health Board marginalised Mr C's needs, with particular reference to the domain of nutrition.

The Health Board agreed to take the following action to resolve the complaint:

- a) Hold an Independent Review Panel into the decision not to award continuing healthcare funding for 2016.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201702165 - Report issued in July 2017

Mr A complained about the length of time that his wife, Mrs A, had waited for hip replacement surgery and the standard of care provided to her when she had the surgery in May 2016.

Due to the amount of unresolved concerns Mr A had following the Health Board's complaint response, the Health Board agreed to provide a further written response no later than 15 September 2017.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201702364 - Report issued in July 2017

Mr X complained that his mother, Mrs Y, caught Norovirus while on a Betsi Cadwaladr University Health Board ("the Health Board") hospital ward, which Mr X said had led to pneumonia. Mr X also complained that the Health Board's response to his complaint was factually incorrect.

The Ombudsman considered that the substantive issue about Mrs Y's care was out of time for investigation, as the care was provided over two years ago.

However, Mrs Y's name and date of death were incorrect in the Health Board's response to Mr X's complaint. Therefore, the Ombudsman asked the Health Board to issue a letter of apology to Mr X, which the Health Board agreed to issue within two weeks of his decision.

Welsh Ambulance Services NHS Trust - Clinical treatment outside hospital Case Number 201702002 – Report issued in August 2017

Mr A complained to the Ombudsman about the excessive time the Welsh Ambulance Services NHS Trust ("the Trust") had taken to attend to his father after he had fallen at home and was unable to move from

the floor. Mr A was also dissatisfied with the manner in which the Trust had responded to his complaint and for its failure to acknowledge shortcomings in the service his father had received.

Upon considering the information available the Ombudsman was of the view that it appeared from the Trust's response to Mr A that some of the explanations needed to address the concerns Mr A expressed might benefit from a joint response from the Trust and the Health Board. This was because it appeared that a significant number of the Trust's ambulances were unavailable because they were committed to caring for patients outside hospitals and could not be dispatched elsewhere.

The Ombudsman considered that a reasonable resolution in the first instance was for the Trust to convene a meeting between Mr A and other family members with representatives from the Trust and the Health Board to respond to his concerns.

A GP surgery in the area of Cwm Taf University Health Board – Clinical treatment outside hospital Case Number 201702587 – Report issued in August 2017

Mr X complained that the Surgery failed to adequately respond to his complaint that the GP had refused to renew his medical certificate without conducting an examination and, that the Practice Manager would not take him and his partner to a private room to discuss his concerns.

The Surgery acknowledged that the response to Mr X's complaint did not meet the requirements of the "Putting Things Right" regulations. The Surgery agreed to

- a) apologise to Mr X for the failure to investigate and respond to his complaint in accordance with the "Putting Things Right" scheme
- b) offer Mr X a redress payment of £50 in recognition of the time and trouble in bringing his complaint to this office
- c) investigate Mr X's concerns and provide a response in accordance with the "Putting Things Right" process, ensuring that his concerns about the GP's decision not to renew the medical certificate without an examination and the Practice Manager's decision not to take him and his partner to a private room to discuss his concerns were addressed.

Hywel Dda University Health Board - Clinical treatment in hospital Case Number 201702292 – Report issued in August 2017

Mr X complained to the Ombudsman in February 2017 that Hywel Dda University Health Board ("the Health Board") failed to provide the urgent attention his daughter's eye condition required, which almost resulted in a loss of sight in one eye and greatly reduced sight in the other. Mr X also complained that there were a number of inaccuracies in the Health Board's initial response to his complaint.

On receiving the initial complaint, the Health Board agreed it would carry out a number of actions in order to resolve the complaint at that early stage, including issuing Mr X with a response.

Mr X then complained to the Ombudsman that, although a number of the actions were carried out, the final response was outstanding 3 months after the Health Board had agreed to "expedite" the complaint response.

The Ombudsman contacted the Health Board who formally agreed to:

- a) send the complaint response by 25 August 2017, and
- b) further apologise to Mr X for the delay.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number 201701665 – Report issued in August 2017

Mrs G and Mrs A complained to Aneurin Bevan University Health Board (“the Health Board”) about the treatment provided to their father following a fall at home, and the palliative and end of life care he received before his death. They also raised concerns about a fall their father had whilst admitted to hospital, and the circumstances around his discharge home. Mrs G and Mrs A met with clinicians and received a full response. In March 2017 Mrs G and Mrs A raised four further questions with the Health Board and requested a further meeting to discuss their concerns.

The Ombudsman found that the Health Board had given assurances that it would meet again with Mrs G and Mrs A, but there had been a slight delay in arranging a suitable date. The Health Board agreed to undertake the following actions in settlement of the complaint:

- a) Apologise for the delay in arranging a meeting;
- b) Arrange and hold a meeting within two months to deal with the four questions identified; and
- c) Provide a copy of the Datix report on the falls incident at, or before, the meeting.

Aneurin Bevan University Health Board - Confidentiality Case Number 201701045 – Report issued in August 2017

Mrs A complained that Aneurin Bevan University Health Board (“the Health Board”) failed to respond appropriately to concerns she raised about treatment received at the Early Pregnancy Assessment Unit. Specifically Mrs A said that there were some questions relating to her care and treatment which were not answered at all.

Further although the Health Board acknowledged some failings in respect of the care provided to Mrs A and offered appropriate apologies, she expressed concern that the response failed to recognise the impact and suffering experienced. Mrs A was also distressed by the use of a clinical term used to describe her experience.

The Ombudsman was satisfied that the majority of the concerns raised by Mrs A were appropriately addressed by the Health Board. It was felt that little further could be achieved by investigation of the failings already acknowledged. However the Ombudsman agreed that some of the specific questions raised by Mrs A had not been addressed by the Health Board in its original response and that distress had been caused by the wording used.

Accordingly the Health Board was asked to:

- a) provide a further written response to Mrs A addressing the questions identified in the complaint to the Ombudsman and apologise for not having done so previously.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201702047 – Report issued in August 2017

Mrs A complained that Betsi Cadwaladr University Health Board (“the Health Board”) had declined to progress a complaint she had made about a number of issues relating to her aunt, Mrs C’s, stay in hospital and concerns about a delay in her discharge. The Health Board insisted that signed consent should either be sought from Mrs C (who lacked capacity) or that a power of attorney for health and welfare matters in favour of Mrs A should be produced. Mrs A only held power of attorney for financial decisions relating to Mrs C.

Whilst accepting that consent is an important requirement for sharing sensitive information with a third party, the Ombudsman felt that the position taken by the Health Board had been unreasonable, after considering the particular circumstances of the case, in that:

- Mrs C was Mrs A’s aunt, living next door to her with Mrs A’s mother
- Mrs A provided daily care to both (and continued to after Mrs C was discharged home) so making decisions about her health and welfare
- The Health Board had asked Mrs A to attend a Best Interest Meeting about Mrs C whilst she was in hospital when health and welfare matters were discussed (given Mrs C lacked capacity)
- Mrs A’s complaint had also included concerns about matters in her own right as well as those said to be on behalf of Mrs C.

The Ombudsman proposed the following recommendations in settlement of the complaint, which the Health Board agreed to implement:

- a) A written apology to Mrs A for the failure to identify her concerns and for not progressing the complaint (her own and that made on behalf of Mrs C)
- b) To offer Mrs A redress of £75.00 for the failing and her time and trouble in having to pursue the matter further
- c) To fully consider Mrs A’s complaints and provide a full response to them within 3 months
- d) To disseminate learning points regarding the receipt of third party complaints and consent to the wider Concerns team.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201703117 - Report issued in September 2017

Mrs M complained about the care and treatment provided to her late father, Mr N, by Hywel Dda University Health Board (“the Health Board”) between November 2015 and January 2016. Mrs M also complained about the Health Board’s complaint handling and failure to provide Mr N’s medical records.

The Ombudsman considered that the substantive issues regarding medical care provided to Mr N were out of time for consideration by his office.

The Health Board’s complaint response, whilst issued outside of the 30 working day target, was not so late as to be considered unreasonable.

The Ombudsman found that there was a significant delay of over six months in the Health Board providing Mrs M with a copy of Mr N's medical records. In settlement of this element of Mrs M's complaint, the Health Board agreed to:

- a) Provide Mr N's medical records to Mrs M by 18 September 2017
- b) Apologise to Mrs M for the delay in providing the medical records by 6 October 2017
- c) Offer a £100 payment to Mrs M by 6 October 2017 in recognition of the time and trouble caused by the delay.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number 201703462 - Report issued in September 2017

Mr X complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") had failed to adequately explain the reasons for his partner's cardiac arrest, and about the way in which the Health Board and Coroner's Office treated him in regards to his next of kin status.

Mr X also raised concerns about delays in responding to his requests for a post mortem report, and for the way the Health Board issued the post mortem report to him via non-secure mail.

In settlement of Mr X's complaint, the Health Board agreed to complete the following actions by 3 November 2017:

- a) Investigate and respond to Mr X's concerns about an agency nurse and IV drip alarms, as outlined in his original complaint
- b) Respond to Mr X's concerns about his treatment as next of kin for his partner
- c) Apologise for the post mortem report not being issued in accordance with its own good practice postal guidance, and without a covering letter
- d) Circulate the good practice postal guidance to all relevant staff
- e) Apologise for the delay in the Consultant's response
- f) Offer a payment of £100 to Mr X in recognition of the distress caused by the Consultant's delay in responding to him.

The Ombudsman considered that Mr X's complaint about the Coroner's Officer was premature for investigation by his office.

Whitecross Dental Care Ltd – Clinical treatment outside hospital Case Number 201703332 - Report issued in September 2017

Mrs X complained about the examination carried out by a dentist at Whitecross Dental Care Ltd ("the Practice") on 24 April 2017 which resulted in a decision being made that she would need five fillings. Mrs X said that she subsequently obtained a second opinion from another Dental Practice which said that she only required one filling. Mrs X said that the Practice wrongly said that she had declined an x-ray during her examination and that this indicated that the form setting this out had been doctored. Mrs X said that she wanted a refund of the price she and her husband paid for their examinations.

As Mrs X did not have the five fillings carried out at the Practice, the Ombudsman was not satisfied that she could be said to have suffered any injustice. Accordingly, he did not investigate the complaint. As the complaint was not made about the examination carried out in respect of Mrs X's husband, the Ombudsman did not consider it reasonable to request the Practice refund that fee. However, the Practice agreed to undertake the following actions in settlement of the complaint:

- a) Within ten working days, provide an apology letter for the error in noting on Mrs X's Health Assessment Form that she had declined an x-ray together with an explanation for how that error occurred.
- b) Provide with that letter a cheque for £14 in respect of a refund of the fee paid for Mrs X's examination.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201701985 - Report issued in September 2017

Mrs E complained about Orthopaedic waiting times for treatment, and a failure on the part of Betsi Cadwaladr University Health Board ("the Health Board") to diagnose two herniated disks in her neck. Mrs E explained that she had raised her concerns with the Health Board formally on 27 March 2017, but had not received a response. Furthermore, despite chasing the Health Board for a reply, Mrs E had not even received an explanation or apology for the ongoing delays.

The Ombudsman appreciated Mrs E's frustration that the Health Board had failed to comply with its policy regarding timescales for dealing with a complaint, and considered that it should undertake the following actions, in settlement of the complaint:

- a) apologise for the continued delay; and
- b) provide the response by 15 September 2017.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201702528 - Report issued in September 2017

Mr and Mrs P had concerns regarding the maternity care Mrs P received in Spring 2015, and the neonatal care provided to their daughter following her birth. Mr and Mrs complained to the Ombudsman about the way Hywel Dda University Health Board ("the Health Board") had handled their concerns. Mr and Mrs P's formal complaint was raised with the Health Board in April 2016, but they had yet to receive a response.

The Ombudsman found that the delays were unacceptable, and that by the time the Health Board was likely to issue a decision letter, Mr and Mrs P would have been waiting 17 months for a response. The Ombudsman decided that this amounted to maladministration.

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

- a) Apologise for the significant delay and provide an explanation for it
- b) Offer £300 time and trouble redress for the delays in complaint handling
- c) Expedite the complaint response; and

d) Complete these actions no later than 30 September 2017.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201702323 - Report issued in September 2017

Mrs X's complaint to Betsi Cadwaladr University Health Board ("the Health Board") centred on the care and treatment received by Mrs Y's late husband prior to his death in September 2016. Since making the complaint on 19 December 2016, Mrs X complains that the Health Board failed to provide updates into the investigation of the complaint, and the final response remained outstanding.

On receipt of the complaint, the Health Board was contacted and it agreed to undertake the following in settlement of the complaint.

- a) Provide the final response to the complaint before 30 September 2017.
 - Provide a payment of £500 and an apology in recognition of the delay in providing a response, and the failure to provide meaningful updates.

Cwm Taf University Health Board – Continuing Care Case Number 201702584 - Report issued in September 2017

Mr J raised concern about whether or not the long term nursing care needs of his late mother met the eligibility criteria for NHS Funded Continuing Healthcare, and whether Cwm Taf University Health Board ("the Health Board") should have been responsible for the cost of the care home fees paid for the period 1 August 2014 to 10 June 2015. Mr J complained that the Health Board had refused to allow an Independent Review Panel to consider the matter further.

The Investigating Officer noted correspondence from the Health Board which confirmed that the decision of no eligibility for the relevant period had been ratified. The Investigating Officer also noted that responsibility for completing the retrospective review had been divided between the Health Board and the All Wales Retrospective Continuing Healthcare Review Team (AWRCHC) which was considering a separate claim period. Whilst the AWRCHC had decided to refer its case to an Independent Review Panel, there appeared to be an element of doubt regarding eligibility. It therefore followed that an Independent Review Panel should be allowed by the Health Board.

The Health Board agreed to present the case to an Independent Review Panel to be convened on 4 October 2017.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201702156 - Report issued in September 2017

Mrs A complained about the care and treatment received by her late husband at Wrexham Maelor Hospital in 2016, before he sadly passed away.

The Ombudsman considered the information available to him and approached the Board which agreed to:

- a) write to the complainant within 20 working days of the date of this letter,
- b) and offer a local resolution meeting to discuss the issues complained of and its response to her dated 23 March 2017.

The Ombudsman believed that this would resolve Mrs A's complaint.

Benefits Administration

EARLY RESOLUTION

Cardiff Council – Benefits Administration

Case Number 201702787 - Report issued in September 2017

Ms A's complaint related to a bailiff visit which she said occurred around May 2016 because Cardiff Council ("the Council") was unable to accept her payment in respect of unpaid council tax and failed to return her telephone calls. Ms A was confused regarding the current position with her council tax accounts.

Although the Ombudsman declined to investigate Mr A's complaint, he recognised that Ms A would benefit from a formal complaints response in relation to this specific incident and a comprehensive summary of her council tax accounts.

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 fully consider and investigate Ms A's complaint about the incident in accordance with its formal complaints policy and provide her with a response
- b) to provide Ms A with a fully comprehensive and clear written summary in relation to her council tax accounts.

Community Facilities, Recreation and Leisure

UPHELD

Raglan Community Council - Other

Case Number 201604323 – Report issued in August 2017

Mrs X complained that Raglan Community Council (“the Community Council”) unfairly rejected her application to renew her allotment plot tenancy and consequently wrongly evicted her from her plot. Mrs X also complained about the Community Council’s handling of her complaint.

In relation to Mrs X’s first complaint, the Ombudsman found that the Community Council failed to appropriately process Mrs X’s request for an appeal of its decision to serve her with a notice to vacate her allotment plot. Consequently, she was unjustly denied the opportunity for her case to be heard by an Appeal Panel, which amounted to maladministration.

In relation to Mrs X’s second complaint, the Ombudsman found that the Community Council failed to adhere to its own complaints procedure when considering Mrs X’s complaint. As a result, Mrs X did not receive a response or satisfactory outcome to her complaint.

The Ombudsman made a number of recommendations in this case including:

- a) a written apology
- b) financial redress, and
- c) a fresh appeal hearing for Mrs X and that the Community Council publishes an appeals procedure.

Complaint Handling

UPHELD

Betsi Cadwaladr University Health Board - Health
Case Number 201603005 - Report issued in July 2017

Mrs X complained that Betsi Cadwaladr University Health Board's ("the Health Board") complaint handling in respect of the care provided to her late husband, Mr X, had been poor, both in relation to the time taken before its final response was provided and the factual inaccuracies the response contained. Mrs X was aggrieved that the Health Board unreasonably changed its position with respect to finding that a breach of the duty of care towards Mr X had occurred. Mrs X also complained that staff had unreasonably decided not to contact her when Mr X's condition deteriorated because of what they deemed her circumstances to have been.

The investigation found that the delays in responding to Mrs X's complaint were wholly unreasonable and unacceptable. There were also clearly significant factual inaccuracies in the final response. The investigation found that the way the Health Board changed its position with respect to the finding of a breach of duty of care was unreasonable given that no proper reason was given for that change. Finally, the investigation found that the failure to contact Mrs X sooner in respect of her husband's deterioration amounted to a failing on the part of the Health Board. These failings caused Mrs X to suffer significant anxiety and distress. The three aspects of this complaint were therefore upheld.

The Health Board agreed to:

- a) provide a fulsome apology to Mrs X for the failings identified above
- b) to share the findings of this report in respect of complaint handling and informing the next of kin so that lessons could be learned from the failings found by this investigation.

NOT UPHELD

City and County of Swansea – Adult Social Services
Case Number 201600964 - Report issued in July 2017

Mr Y complained that City and County of Swansea ("the Council") provided incorrect information about the availability of, and Mrs X's eligibility for, a Disabled Facilities Grant ("DFG") for garage conversion works to her property in 2014. As a result Mr Y complained significant unnecessary expenditure was incurred as Mrs X paid for the garage conversion.

Mrs X was in hospital following a fall. She wanted to be discharged home but Mr Y, her son, disagreed based on concerns for her safety and her risk of falls. Mrs X was deemed to have capacity to decide where she wished to live when discharged from hospital, and an appropriate care plan was arranged to meet Mrs X's care needs and to address the safety concerns for her return home. Prior to Mrs X's discharge Mr Y informed the Council that Mrs X had agreed to defer her discharge home until a garage conversion was completed. The Council discussed Mr Y's plans with Mrs X and the DFG process. Mrs X confirmed she had agreed to the garage conversion provided the works were completed quickly, and she

did not wish to apply for a DFG as this would delay her discharge home.

The investigation found that Mrs X had capacity to decide where she wished to live on discharge from hospital, Mrs X wanted to be discharged home, and as the owner of the property, Mrs X did not want to delay her discharge by applying for a DFG. The Ombudsman found this was a decision Mrs X was entitled to make and Mr Y's complaint was not upheld.

Cardiff Council – Various other

Case Number 201701278 - Report issued in July 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
- b) Apologise for the confusion and delays; and
- c) Provide a response to the complaint and the query by 30 June 2017.

Tai Ceredigion Cyf - Housing

Case Number 201701544 - Report issued in July 2017

Ms X complained on behalf of Ms Y that Tai Ceredigion Cyf ("the Association") had failed to provide adequate reasons why it would not alter a window to provide a door for Ms Y to have access to her garden. Ms X also complained that the Association had failed to respond to Ms Y's letter to it appealing its decision.

The Association informed the Ombudsman that it had received Ms Y's appeal letter in January 2017, but that it had not been passed to the relevant officer for consideration. The Ombudsman considered that this amounted to maladministration, and agreed the following actions for completion by the Association by 8 August 2017:

- a) Provide a written apology to Ms Y for failing to respond to her appeal letter
- b) Issue a written response to Ms Y's appeal letter
- c) Offer a payment of £50 to Ms Y for the time and trouble in raising the complaint with the Ombudsman.

EARLY RESOLUTION

Flintshire County Council – Adult Social Services

Case Number 201702030 – Report issued in August 2017

Mrs X complained that the Council refused to make amendments to a report which was prepared following a meeting with her and her brother regarding their father's care.

The Ombudsman noted that the Council had amended errors where it referred to Mrs X's brother as a female but after speaking to staff who attended the meeting it believes the remainder of the report is accurate.

However, the Ombudsman was disappointed to also note that the Council had not apologised to Mrs X for the errors it had acknowledged and changed. The Council has therefore agreed to apologise.

Flintshire County Council – Roads and Transport Case Number 201702683 – Report issued in August 2017

Mr X complained that Flintshire County Council ("the Council") had failed to respond to his complaint about a road island that had been positioned outside his property which made it difficult for him to drive from his property when using a trailer.

The Ombudsman found that the Council had received the complaint in June 2017, but had failed to issue a formal written response in line with its complaints procedure.

The Council agreed to complete the following actions by 18 August in settlement of Mr X's complaint:

- a) Issue its Stage 1 complaint response to Mr X
- b) Apologise for the delay in responding to Mr X

Abertawe Bro Morgannwg University Health Board - Health Case Number 201603293 – Report issued in August 2017

Ms T complained that an out of hours general practitioner had failed to consider her previous medical history during a telephone consultation on 7 May 2016. This resulted in her not being prescribed antibiotics for her suspected tonsillitis. She was of the opinion that this had caused a 'flare up' of an ongoing Psoriasis condition that she suffers with.

She also complained of being unhappy that she was not offered a 'face to face' meeting at the consultation or complaint investigation stage.

Abertawe Bro Morgannwg University Health Board was contacted and it agreed to write to Ms T:

- a) apologising for the apparent lack of communication thus far
- b) Offering her an opportunity to attend a local resolution meeting with relevant staff.

The offer of a local resolution meeting will be made within 10 days of this decision letter and the offer dates within 20 working days thereafter.

City and County of Swansea - Adult Social Services Case Number 201700916 – Report issued in August 2017

Mrs A complained to the Ombudsman about the City and County of Swansea's ("the Council") implementation of an action plan arising from an independent investigation of her complaint. Mrs A said that the actions had not been addressed by the Council in a robust manner.

On receipt of Mrs A's complaint, the Ombudsman contacted the Council and it agreed to undertake the following in settlement of the complaint:

- a) To keep recommendations 1 and 2 open pending completion of a wider service review and implementation of any further actions arising.
- b) To keep recommendation 6 open pending confirmation that the requirement for contractors to co-operate with the statutory Complaint Process is included within the Social Services contract template.
- c) To provide evidence of compliance with the open recommendations directly to the Ombudsman.

Betsi Cadwaladr University Health Board - Health

Case Number 201702719 - Report issued in September 2017

Ms X complained about Betsi Cadwaladr University Health Board's ("the Health Board") complaint handling and in particular, that she had not received a final response.

Upon considering the complaint the Ombudsman was disappointed to note the number of times Ms X felt it necessary to contact the Health Board to chase its position with its investigation.

The Ombudsman therefore contacted the Health Board to discuss the concerns. Since contacting the Health Board, it has concluded its investigations and sent a Putting Things Right response to Ms X.

Betsi Cadwaladr University Health Board - Health

Case Number 201703197 - Report issued in September 2017

Mrs X (an advocate) complained that her Client had not received a "Putting Things Right" response from Betsi Cadwaladr University Health Board ("the Health Board") to a complaint which was submitted in December 2016. Putting Things Right is the commonly used name for the arrangements under which complaints against the NHS in Wales are considered.

The Ombudsman contacted the Health Board and it agreed to resolve the complaint by:

- a) writing to Mrs X's Client with its response by 13 October 2017
- b) including an apology for the delay within that response.

Carmarthenshire County Council – Various other

Case Number 201702289 - Report issued in September 2017

Mr F complained that Carmarthenshire County Council ("the Council") failed to respond to correspondence dating back to 27 April 2017, regarding his concerns about the siting of two large refuse bins to the front of his property. Mr F explained that the siting of the bins "encourages contravention of the Highway Code" regarding waiting and parking provisions.

The Ombudsman found that although two of Mr F's letters were received by the Waste Management Service, the Council's internal mail systems did not process and distribute all his letters correctly. Consequently Mr F's first three letters were received by the Council but failed to reach the relevant team. The Council responded to Mr F's fourth and fifth letters, but these were returned by Royal Mail uncollected.

The Council agreed to undertake the following actions within three weeks of the date of the Ombuds-

man's decision, in settlement of the complaint:

- a) Apologise for the failures in processing and distributing the correspondence correctly and effectively; and
- b) Ensure that all relevant staff members are made aware of these events, and the importance of ensuring that mail is delivered appropriately to the relevant departments.

Abertawe Bro Morgannwg University Health Board - Health Case Number 201701893 - Report issued in September 2017

Ms A complained about significant delays by Abertawe Bro Morgannwg University Health Board ("the Health Board") when investigating her complaint about her father's treatment and care. This meant that the statutory limitation period of three years to be able to bring a legal claim had now passed.

In recognition of the unacceptable delay, the Health Board agreed to:

- a) include an apology and redress payment of £250 with its complaint response and; to
- b) consent to the extension of the limitation period in this matter, by 12 months from the date of the complaint response, in order that Ms A did not lose the opportunity to bring a legal claim thereafter, should she wish.

Hywel Dda University Health Board - Health Case Number 201702324 - Report issued in September 2017

Mrs X complained that after initially raising her concerns with Hywel Dda University Health Board ("the Health Board") in July 2016, the complaint response remained outstanding. Mrs X also claimed that the Health Board failed to provide an anticipated response date.

On receipt of Mrs X's complaint, the Health Board were contacted and agreed to undertake the following in settlement of her complaint.

- a) Provide Mrs X with an apology and explanation for the delay in providing the final complaint response.
- b) Provide Mrs X with a payment of £500 in recognition of the time and trouble in having to take her complaint to the Ombudsman, and acknowledgement of poor complaint handling.

Education

EARLY RESOLUTION

Bridgend County Borough Council – Admissions, procedures and appeals

Case Number 201701286 - Report issued in July 2017

Mr & Mrs A complained that Bridgend County Borough Council (“the Council”) refused a nursery place for their child despite meeting the published in-catchment criteria. Mr & Mrs A were not afforded a right of appeal under the Council’s admissions process and pursued this matter as a complaint. Although the Council subsequently reviewed the matter and allocated a place to their child Mr & Mrs A were concerned that there had been a lack of transparency in the decision making process. In particular Mr & Mrs A became concerned that the Council may have applied additional unpublished criteria to refuse their application.

The Ombudsman noted that conflicting information had been given to Mr & Mrs A to explain why their application was initially refused. Although the Ombudsman was satisfied on balance that the decision had been taken appropriately by the Council it was noted that there was an omission in the published criteria for nursery places.

As a means of resolving the issues identified the Council agreed to:

- a) apologise to Mr & Mrs A for any distress has caused and explain how it processed their application.
- b) pay £100 to Mr & Mrs A in recognition of the investment of time and trouble taken to pursue this matter.
- c) amend the nursery element of its published admission policies for by the inclusion of the omitted additional criteria.

Environment and Environmental Health

EARLY RESOLUTION

Wrexham County Borough Council - Refuse collection, recycling and waste disposal
Case Number 201701915 - Report issued in July 2017

Ms X complained that, for over a year, the Council had repeatedly failed to collect her refuse and recycling although she is on the assisted collection scheme.

The Ombudsman was disappointed to note the number of times Ms X found it necessary to report missed collections, especially in light that she was advised in February 2017 that the matter had been resolved. It is apparent from discussions with the Council that it has taken steps to ensure no further collections will be missed.

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

- a) Write to Ms X with its apologies and confirm the actions it has taken post the complaint response of 24 February 2017;
- b) Offer a redress payment in the amount of £50.00 for the inconvenience this matter has caused.

Vale of Glamorgan Council – Refuse collection, recycling and waste disposal
Case Number 201701245 - Report issued in July 2017

Ms P complained that she had not received a response from Vale of Glamorgan Council ("the Council") to her complaint about the garden waste refuse collection service she receives. Ms P submitted her complaint in October and chased it in November 2016, but did not receive a response. When the garden waste collection began again in March 2017, Ms P contacted the Council again, and the Council agreed to provide replacement bags, but they were not delivered and she still had not received a response to her original complaint from last year.

The Ombudsman found that the Council missed opportunities to deal comprehensively with Ms P's complaint and, further, had promised, but failed to deliver on some remedial action, with the result that she had waited over eight months for a satisfactory response.

The Council agreed to undertake the following actions, within four weeks of the Ombudsman's decision letter, in settlement of the complaint:

- a) Provide a Stage 2 written response to the original complaint
- b) Ensure the 10 replacement bags are promptly delivered
- c) Offer financial redress of £50 for Ms P's time and trouble in bringing the matter to the Ombudsman.

Housing

NOT UPHELD

Vale of Glamorgan Council- Applications, allocations, transfers and exchanges

Case Number 201603274 - Report issued in July 2017

Ms A complained about Vale of Glamorgan Council'S (the Council'') refusal to consider her as a priority for re-housing, despite health professional support that her current accommodation was detrimental to her and her family's health.

The Ombudsman's investigation concluded that the Council had been proactive in trying to address Ms A's housing concerns. It had reviewed her case on receipt of further supporting evidence but had determined she did not meet the criteria for immediate re-housing priority. Given Ms A's need to move, the Ombudsman found that the Council had exercised its discretion and placed on her the housing register. The Ombudsman, in the absence of administrative failing, found no grounds to criticise the Council's actions. Ms A's complaint was not upheld.

Trivallis - Neighbour disputes and antisocial behaviour

Case Number 201604677 - Report issued in August 2017

Mrs X said that she had been the victim of her neighbours anti social behaviour since March 2016, and despite numerous complaints, Trivallis Housing Association (''Trivallis'') failed to take action to resolve the matter. Mrs X also complained that Trivallis failed to adequately respond to her complaint.

The investigation found that Trivallis had undertaken reasonable and proportionate action to address the concerns of anti social behaviour Mrs X reported. The investigation also found that Trivallis had responded to Mrs X's concerns and that its response and the associated actions were reasonable.

The complaint was not upheld.

EARLY RESOLUTION

Grwp Cynefin – Right to Buy

Case Number 201701152 - Report issued in July 2017

Mrs J complained that Grwp Cynefin (''the Group'') had failed to correctly administer her application to purchase the property that she resided in with her late husband. This resulted in an increased valuation of the property by £2,000.

She also complained that the Group had failed to carry out cyclical maintenance work in a timely manner and that much of the work was poor in quality.

The Ombudsman considered that the matters complained of should not be investigated. It contacted the Group which agreed to;

(a) Write a letter to the complainant requesting confirmation of her wish to proceed with the purchase of the property.

This will be completed within 20 working days of the date of this summary.

The Ombudsman considered that the action promised by the Group was reasonable.

Trivallis - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number 201605406 - Report issued in August 2017

Ms A complained that the adaptation work Trivallis ("the Housing Association") had carried out to install a ramp meant she was now unable to access the property using her mobility scooter. She also expressed dissatisfaction with repair work carried out to her kitchen floor.

The Ombudsman concluded that the adaptation work the Housing Association had initially undertaken had worsened Ms A's situation as a disabled person. He also identified shortcomings in the way the Housing Association carried out its adaptations and reminded the Housing Association of its wider equality duty when it came to meeting the needs of its disabled tenants.

As part of the settlement on this case the Housing Association set out some of the changes it had introduced as a result of Ms A's complaint. It also said that it would be carrying out a review of its adaptations policy. The Housing Association agreed to:

- a) apologise to Ms A for the failings identified
- b) pay her £500, and
- c) reflect on its equality duty and what additional measures it might need to implement to ensure compliance with that duty.

Planning and building control

UPHELD

Flintshire County Council - Handling of planning application (other)

Case Number 201603333 - Report issued in July 2017

Miss X complained that Flintshire County Council ("the Council") did not give proper consideration to a planning application. She also complained about the way the Council handled her complaint.

In relation to the first complaint, that the Council failed to give proper consideration to a planning application, the Ombudsman found that the Council failed to adequately demonstrate that it appropriately considered the listed status of the property when reaching its decision to grant temporary planning permission. However, this did not result in an injustice to Miss X and therefore the complaint was not upheld.

In relation to the second complaint, the Ombudsman found that there was a delay in responding to Miss X's complaint and that the Council did not provide Miss X with an explanation for the delay. The complaint was upheld and the Ombudsman recommended that the Council apologised to Miss X.

NOT UPHELD

Gwynedd Council - Rights of way and public footpaths

Case Number 201602184 - Report issued in August 2017

Mr A complained on behalf of his partner Ms B, who owns a property ("the House") in the area of Gwynedd Council ("the Council"). Mr A complained about the Council's decision to create a public right of way across Ms B's property. Specifically, that the Council failed to:

- Fully consider alternative routes for the right of way, in particular those proposed by Ms B, and provide reasons for rejecting them
- Inform Ms B that she would be responsible for enforcing any trespass by cyclists using the right of way.

The Ombudsman found that, in specific circumstances, the Council could create a right of way across a piece of land owned by a third party irrespective of whether the landowner agreed. The Council, having considered the alternative routes available, concluded that the proposed route across Ms B's property was the preferred option and provided Ms B with a reasoned explanation.

The Ombudsman also found that Ms B had been represented by a solicitor and consultant and, that it had been open to her to discuss those matters during the negotiation stages of the process. Furthermore, there was no intention to promote the new right of way as a cycle path, and that the Council had agreed to place appropriate signage in the area. The Ombudsman did not uphold the complaint.

EARLY RESOLUTION

Vale of Glamorgan Council – Handling of planning application (other)

Case Number 201701962- Report issued in July 2017

Mr X complained that the Vale of Glamorgan Council (“the Council”) had given very little consideration to his family’s privacy when granting planning permission for a decking area to his neighbour’s property.

The Ombudsman, having sought advice from his Professional Adviser, found no evidence that the Council’s decision to grant planning permission was reached in an improper manner, being the extent of his jurisdiction.

The Council’s report did not explicitly evidence its consideration of the impact of the decking area on Mr X, although its subsequent complaint response provided explanations which appeared to be reasonable. The Council also offered Mr X a remedy in that he could erect an enclosure for privacy; however, it did not specify what could be erected without Mr X applying for planning permission.

The Council agreed to complete the following actions by 11 August 2017:

- a) Apologise to Mr X that the officer’s consideration of the impact of the decking area on him was omitted from the report
- b) Remind officers of the importance of including such considerations in reports
- c) Write to Mr X to clarify what enclosure he might erect without requiring planning permission.

Self funding care provider

EARLY RESOLUTION

Wrexham County Borough Council – Domiciliary care

Case Number 201701995 - Report issued in July 2017

Miss X complained that the findings made in a Formal Investigation of a Social Services complaint completed on behalf of the Wrexham County Borough Council ("the Council") were based on hearsay and gossip. One of her four complaints was upheld.

The Ombudsman was satisfied that the Formal Investigation report was completed using an appropriate method and that the conclusions reached were reasoned and based on direct evidence provided. Whilst noting that Miss X disputed the evidence and conclusions reached it was determined that little further could be achieved by investigation of these issues by the Ombudsman.

However when considering the Council's response to findings of the Formal Investigation the Ombudsman felt that a further and meaningful response should have been provided to her recognising the impact and effect of the failing identified on Miss D and her family. The Council therefore agreed to provide the following in resolution of this concern:

- a) A further complaint response in respect of the upheld complaint.
- b) Apology in respect of this failing and for not having provided a meaningful apology previously.

Social services - Adult

EARLY RESOLUTION

Cardiff Council – Services for people with a disability Case Number 201701492 - Report issued in July 2017

Mr and Mrs T complained that Cardiff Council ("the Council") had failed to consider the needs of people with disabilities including them, when it decided to transfer the management of one of its Leisure Centres to a private contractor. They also complained that following a meeting with the Council in September 2016, it failed to respond to question they sent it in relation to the transfer. They further complained that the Council had failed to properly deal with the complaint they made to it about its non response to their initial questions.

The Ombudsman considered the information available to him and decided found that there were no grounds to investigate the first and last part of their complaint.

He did, however, consider that the Council should have responded to the initial questions posed by the complainants following their initial meeting.

He contacted the Council and it agreed to:

- a) write to the complainants apologising for failing to reply to their initial questions.
- b) offer a payment of £50 in recognition of the time and trouble taken by them in pursuing the initial response from it.

The Council stated that it would complete this within 20 working days of the date of the letter.

Conwy County Borough Council - Other Case Number 201701859 - Report issued in August 2017

Mrs A complained that her sister's social worker made a referral regarding her son's family to the Conwy County Borough Council's ("the Council") Children's Social Services department contrary to her agreement with the Council. Mrs A also complained about the current care package and facilities being provided to her sister and about the communication issues between her and Social Services. Finally, she complained that her sister had been assigned a male social worker.

Although the Ombudsman declined to investigate Mrs A's complaint about the anonymous referral, as matters relating to child protection could not form part of any such agreement, he contacted the Council to discuss Mrs A's outstanding concerns who confirmed that certain action had already been taken and/or would be taken to resolve these matters as follows:

- a) Mrs A's sister's social worker had been changed who is the new point of contact
- b) To contact Mrs A to arrange a meeting, during which Mrs A's concerns about the current situation will be fully discussed, including the issue of her sister's mobility and the provision of a stair lift and downstairs toilet within the home, and

- c) to consider whether a further Occupational Therapy assessment ought to be carried out.

Supporting evidence of the outcome of this contact to be provided to the Ombudsman within one month.

Ceredigion County Council - Services for vulnerable adults (eg with learning difficulties, or with mental health issues)

Case Number 201701807 - Report issued in August 2017

Mr X complained about a number of issues surrounding a care package provided to him by Ceredigion County Council's Social Services Department ("the Council"). The Council had offered Mr X a complaint investigation under stage two of its Social Services complaint procedure however he had concerns about the process and instead referred the complaint to the Ombudsman.

In accordance with the Social Services Complaints Procedure (Wales) Regulations 2014, the Ombudsman decided that Mr X's complaint should be referred back to the Council to be dealt with under stage two of the Social Services complaints procedure. The Council agreed to this course of action and also agreed that Mr X would be offered the support of an advocate and a choice of two independent investigating officers to meet his needs.

If Mr X remained dissatisfied when he had received the report at the end of the stage two process the Ombudsman confirmed that his office could be approached again.

Hywel Dda University Health Board - Services for vulnerable adults

Case Number 201702389 - Report issued in September 2017

Mr X complained that Cardiff Council ("the Health Board") failed to respond to his complaint concerning the care of his daughter.

Upon discussing Mr X's complaint with the Health Board he was advised that a response was recently sent. However, it recognised there was a nine month delay in finalising its investigation and, therefore, agreed to undertake the following in settlement of this complaint:

- a) Write to Mr X to apologise for the delay in finalising its response;
- b) Include a meaningful explanation of the delays in finalising its investigation;
- c) Offer a financial redress payment for time and trouble and recognition of the nine month delay in the sum of £150.00.

Pembrokeshire County Council – Services for vulnerable adults

Case Number 201701536 - Report issued in September 2017

Mr A complained that, whilst he was resident at a Cardiff Council ("Council") reablement facility, staff disposed of two black bags of his shoes and trainers that were stored in the attic.

On receipt of the complaint, the Ombudsman contacted the Council and it agreed to:

- apologise to Mr A for disposing of his belongings,



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- make a redress payment of £225 to compensate Mr A for his loss and the distress and inconvenience caused; and to
- provide Mr A with an explanation of the changes made to prevent this from happening to anyone else.

Social Services – Children

UPHELD

Merthyr Tydfil County Borough Council - Other
Case Number 201601000 - Report issued in July 2017

Mr B, a looked after child, complained that Merthyr Tydfil County Borough Council's ("the Council") Social Services had let him down and had not provided him with sufficient psychological support to enable him to address his mental health issues. This had affected his education. Mr B also complained that the Council had failed to help him join a football club's Academy.

The Ombudsman did not identify any undue delay on the part of the Council. He found evidence that the Council had worked with agencies/individuals to try to obtain the necessary support for Mr B and where necessary had liaised and met with them as well as escalating concerns to senior management. The Ombudsman did not uphold this part of Mr B's complaint.

In relation to Mr B's complaint about the football club, shortcomings in record keeping meant it was not possible to be clear as to the sequence of events. To that extent the Ombudsman upheld this part of Mr B's complaint.

By way of recommendation the Council was asked to issue a general reminder to staff about the importance of record keeping.

EARLY RESOLUTION

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

Case Number 201701070

Ms X, an advocate, complained on behalf of her client, Ms Y, about the way in which the Council had provided services for her daughter, who was subject of a Care Order.

The Ombudsman considered the complaint and asked Bridgend County Borough Council ("the Council") to arrange for an independent investigation to be carried out under Stage Two of the Social Services Complaints Procedure. The Council agreed to do so and the Ombudsman considered this to be an appropriate resolution to the complaint.

Powys County Council - Other

Case Number 201701151

Mr X complained that Powys County Council ("the Council") did not investigate his Social Services complaint at Stage 2 of its procedure. The Ombudsman considered that in accordance with the Social Services Complaints Procedure (Wales) Regulations 2014 ("the Regulations"), the Council was not able to have refused to have done so.

The Council agreed to take the following actions to resolve the complaint:

- a) Apologise to Mr X for its failure to undertake a Stage 2 investigation

- b) Undertake a Stage 2 investigation and provide a report within 25 working days
- c) Remind relevant staff of the content of the Regulations, with particular reference to the procedures with regard to Stage 2 investigations.

Cardiff Council - Children in care/taken into care/'at risk' register/child abuse/custody of children Case Number 201702018 - Report issued in August 2017

Mrs F complained that she had made a complaint to Cardiff Council ("the Council") which had not been investigated. The complaint was about the care her adopted child had received in foster care, it also raised concerns about a child which remains with the foster carers. The Council undertook a child protection investigation in relation to the child who remains in foster care but did not investigate the complaint about the standard of service received by Mrs F's adopted child.

The Council acknowledged that failing to address the complaint using its complaints procedure was an oversight and agreed to undertake a stage two (independent) investigation into the complaint. Mrs F agreed that this would settle her complaint.

Pembrokeshire County Council - Other Case Number 201701576 - Report issued in August 2017

Mr A complained that Pembrokeshire County Council's ("the Council") Social Services Department failed to adequately address concerns he raised about the actions taken by officers prior to and during Court proceedings in respect of to his grandchildren. Specifically Mr A disputed that enquiries were made with him as a potential long-term carer and said that his calls were not responded to.

The Ombudsman considered the response provided by the Council and agreed that it contained a limited explanation of the events, failed to explain what evidence had been considered or information sought when responding to the complaint and/or the rationale for decisions taken.

In addition the Ombudsman noted that the response failed to provide information to Mr A in relation to the relevant complaints procedure.

As a means of early resolution the Council agreed to:

- a) undertake an internal review of events and produce a written response. In doing so the Council will provide information on the complaints procedure to Mr A.
- b) apologise to Mr A for not having provided information previously.
- c) remind relevant staff of the obligations under complaints procedure.

Various Other

UPHELD

Cardiff Council – Other miscellaneous

Case Number 201602784 - Report issued in July 2017

Mr S complained about the actions of Cardiff Council (“the Council”) between 2011 and 2016 in relation to the proposed grant of a lease of land (“the land”) at the intersection of two major roads (“the junction”) in the Council’s area. Mr S intended to use the land for a used car sales business. The proposed lease was first drafted in 2011, but the negotiations over the terms of an agreement relating to the grant of planning consent meant that it had not been completed by the end of 2015. In February 2016 the Council told Mr S that the land was needed in connection with its Local Transport Plan, and withdrew the offer of a lease.

The Ombudsman upheld the complaint. He found that the Council’s initial insistence on large-scale high-ways works being required for the agreement, only to subsequently accept lesser work, amounted to maladministration. This had led to a delay in the completion of the agreement and, thus, the opportunity for the lease to have been completed in a timely manner or at all. The Council’s failure to inform Mr S that the land might be required for its Local Transport Plan was also maladministration.

The Ombudsman recommended that the Council apologise to Ms S, and reimburse him for the costs he had incurred, as well as making a payment of £3000 to him in recognition of his time and trouble in attempting to obtain a lease. He also recommended that the Council review its processes for internal communication.

NOT UPHELD

Carmarthenshire County Council – Economic Development

Case Number 201604969 - Report issued in July 2017

Mr H complained that there were flaws in a tendering exercise carried out by Carmarthenshire County Council (“the Council”). In particular, he was concerned that his Company had lost out due to shortcomings in how the quotes were assessed by the Council.

The Ombudsman found that there was no evidence that the Council’s assessment of the rival tenders was flawed. The tenders were assessed in the same way against the same criteria. Whilst the information provided to the bidders beforehand could have been clearer, this affected all the bidders equally. The Ombudsman did not uphold the complaint.

EARLY RESOLUTION

Conwy County Borough Council - Poor/No communication or failure to provide information

Case Number 201702502 - Report issued in August 2017

Mr T complained that Conwy County Borough Council (“the Council”) had failed to reply to his request for a meeting to discuss ongoing issues regarding flooding on the road outside his home. Mr T stated that he had contacted the Council in March 2017 and again in April, but, had not received a reply.

The Ombudsman discovered that the Council had initially sent an email to the complainant offering a number of dates, but, he had replied without including the Council's email address in his communication.

The Ombudsman contacted the Council and they agreed to write to the complainant within ten 10 working days of the date of this letter, offering further dates for a meeting.

The Ombudsman considers that this action will resolve Mr T's complaint.

Natural Resources Wales - Poor/no communication or failure to provide information

Case Number 201702437 - Report issued in September 2017

Mr S complained that Natural Resources Wales ("NRW") had caused a number of problems and disruption to his daily life during tree felling operations on its land near his home. He also complained that its communication and complaint handling had been poor.

The Ombudsman found that the majority of issues raised in his complaint were matters of liability and fell outside his jurisdiction. He did, however, find that there some issues had not been fully addressed.

He contacted NRW who agreed to:

- a) write a letter to Mr S providing him with a response to six outstanding matters and, where required, a target date for completion of the action concerned.

It was agreed that this would be completed within 20 working days of the date of this letter.

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:

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 0300 790 0203
Fax: 01656 641199
e-mail: ask@ombudsman-wales.org.uk (general enquiries)

Follow us on Twitter: [@OmbudsmanWales](https://twitter.com/OmbudsmanWales)

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