

The Ombudsman's Casebook

Issue 28 April 2017

News

Ending Groundhog Day!

The Ombudsman published his second thematic report of the past 12 months entitled Ending Groundhog Day: Lessons from Poor Complaints Handling.

He warned that a fear and blame culture needed to be tackled by senior staff across Welsh public bodies to ensure patterns of poor complaint handling don't continue.

You can read the full report [here](#).



Ending Groundhog Day Lessons from Poor Complaint Handling



Developing an approach for consideration of human rights in casework

Human rights have always been a grey area for Ombudsmen. However recent work carried out by the Northern Ireland Public Services Ombudsman (NIPSO) and the Northern Ireland Human Rights Commission (NIHRC) has emphasised the importance of the consideration of human rights in Ombudsman casework.

The Public Services Ombudsman for Wales is currently trialling a tool designed to help investigators do just that, and one of our investigators has written an article about it for the UK Administrative Justice Institute's blog.

[Click here](#) to read the article.

Reaching out to the third sector

In March we exhibited at the first ever Wales Council for Voluntary Action annual conference at the Cardiff City Stadium.

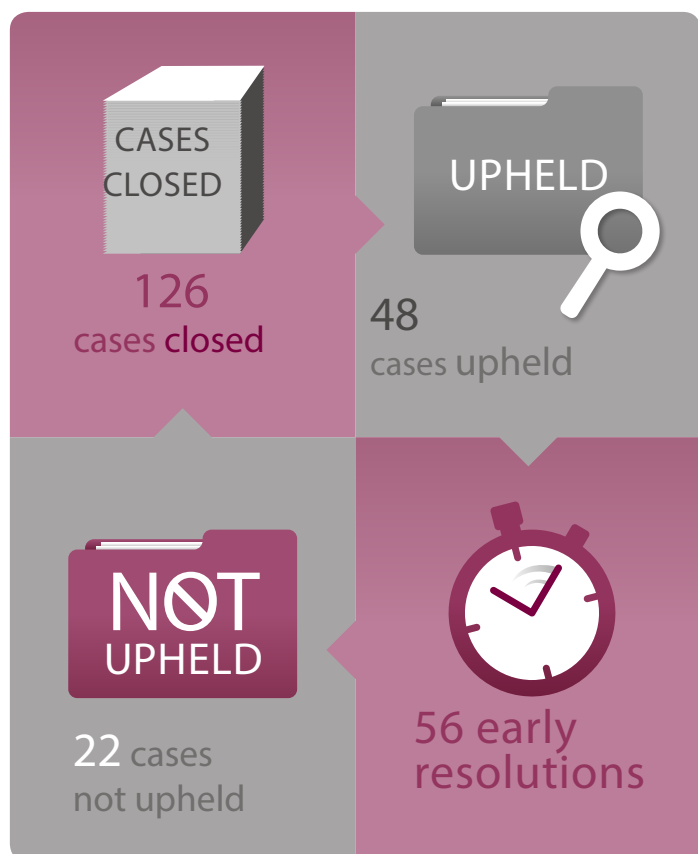
The conference was a great opportunity to raise awareness of our work amongst third sector organisations that support our customers.



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Casebook in numbers



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

Please note the early resolutions category also includes voluntary settlements.

Health

UPHELD

A GP Practice within the area of Cwm Taf University Health Board – Clinical treatment outside hospital Case Number 201506764 – Report issued in January 2017

Mr X complained that GPs at the GP Practice (“the Practice”) failed to properly examine and advise him about a testicular lump when he attended between 2013 and 2015. Mr X said there was a delay in the diagnosis and referral for treatment of testicular cancer by the Practice, which resulted in potentially avoidable surgery in September 2015.

The investigation found that Mr X was examined by Drs A, B and C from 2013 to 2015. The Ombudsman concluded that the care provided by Drs A and C was appropriate. The Ombudsman found shortcomings in Dr B’s consideration of Mr X’s symptoms which should have resulted in him being referred for further treatment. The Ombudsman found nothing to suggest that Mr X would have definitively avoided surgery.

The Ombudsman upheld the complaint as a result of Dr B’s failure to refer Mr X in a timely manner and the subsequent uncertainty which he experienced.

The Ombudsman recommended that:

- a) the Practice should apologise to Mr X for failing to refer him for further treatment and
- b) that Dr B should ensure that an anonymised copy of this report is included in the supporting documentation provided to his NHS appraiser for discussion at his next appraisal.

The Practice agreed to implement the recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201600462 – Report issued in January 2017

Mrs M complained about the treatment she received at an Emergency Department (ED) in March 2012 when she presented with an eye complaint. She considered that had she received treatment sooner than she did, she would not have lost sight in her eye. She also complained about the time taken by Betsi Cadwaladr University Health Board (“the Health Board”) to issue its formal written response to her complaint and the delay in providing its follow up response to the issues raised about the content of its initial response.

The Ombudsman found that there was a delay in Mrs M being seen by a doctor in the ED (the Health Board had previously acknowledged this). However, he was unable to conclude that the outcome for Mrs M would have been different had there been no delay. He did not uphold this complaint. The Ombudsman identified shortcomings in the Health Board’s handling of Mrs M’s complaint and upheld this element of the complaint. The Health Board agreed to:

- a) apologise to Mrs M
- b) pay her redress of £500, and
- c) provide proof of an amendment to one of its practices.

A GP in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital Case Number 201505275 – Report issued in January 2017

Mr A complained that his GP had missed obvious signs of the worsening of his diabetic condition and had failed to carry out a blood glucose test. He said that as a result, he was hospitalised as an emergency with diabetic ketoacidosis and had to spend several days in hospital.

The Ombudsman found that the GP did not do a basic test which would have helped him identify the presenting problem. In view of Mr A's pronounced symptoms, a glucose or HbA1c test should have been done. In addition, the decision to prescribe steroids to Mr A was not based on relevant clinical findings. The Ombudsman upheld the complaint. He concluded that, whilst the course of Mr A's illness might not have been changed, and that he may well have needed hospital care, the situation would not have got to the point of crisis requiring emergency hospital admission. He recognised that this caused additional distress to Mr A and his family. He recommended that the GP pay £500 financial redress to Mr A in recognition of this.

A dental practice in the area of Powys Local Health Board - Clinical treatment outside hospital Case Number 201603176 – Report issued in January 2017

Mrs H complained about the standard of dental care provided to her young son, G. She said that the dentist had failed to notice or highlight to her the extent of the decay present in G's teeth. Specifically she stated that at a check-up appointment, she was advised that G needed two fillings. Two months later, he had an abscess and ended up having 12 teeth extracted.

On investigation, the dental records indicated that there was recognition of a high level of risk of decay for G by the Dental Practice. Oral hygiene advice was given appropriately, and the level of compliance with that advice is outside the dentist's control. It was clear that there was some discussion with G's parents about decay and required restorative work, but it was impossible to know the nature of those discussions. However there were additional preventative treatments which should have been discussed and offered by the Practice in line with NICE guidance. The Ombudsman therefore partly upheld the complaint and recommended that the Dentist concerned and the Practice should use this as a learning opportunity in relation to preventative treatment for children.

Aneurin Bevan University Health Board - Clinical treatment outside hospital Case Number 201504530 - Report issued in January 2017

Ms B complained that her partner, Mr C, did not receive adequate medical or nursing care during his hospital stay. Ms B also complained that Aneurin Bevan University Health Board ("the Health Board") failed to contact her when Mr C's condition deteriorated the night before he died.

The Ombudsman found that the medical care was reasonable but that although the nursing care was generally reasonable, there was a concern about the hygiene standards on the ward, therefore the

complaint about nursing care was partially upheld. The Health Board agreed to review hygiene standards on the ward to address this concern.

The Ombudsman also found that the Health Board should have contacted Ms B when Mr C's condition deteriorated. The Health Board had already acknowledged this in the complaint correspondence and apologised for this, therefore no further action was necessary.

Cwm Taf University Health Board and Cardiff and Vale University Health Board Case Number 201600924 / 201601196 – Report issued in January 2017

Ms B complained about the care her partner, Mr A, received. Ms B said the actions of the clinicians at Cardiff and Vale University Health Board ("the first Health Board") resulted in Mr A suffering from a gangrenous bowel, which caused his death. Ms B also complained that Cwm Taf University Health Board ("the second Health Board") did not provide adequate medical and surgical care to prevent Mr A's health from deteriorating and that communication between the two Health Boards was poor.

The Ombudsman found that the actions of the clinicians in the first Health Board did not result in Mr A suffering from gangrenous bowel. He found that the clinical care provided by the second Health Board could have been improved. Earlier consideration should have been given to the reasons why Mr A's condition did not improve as expected and this may have resulted in earlier identification of gangrenous bowel. Earlier identification may have resulted in earlier surgical intervention. The prognosis for Mr A would still have been poor, but this failing resulted in distress and uncertainty for Mr A's family. The Ombudsman also found that communication between the two Health Boards was poor and that the first Health Board should have made a referral to the palliative care team, to support Mr A and his family.

The first Health Board agreed to apologise to Ms B for failing to involve the palliative care team.

The second Health Board agreed to:

- a) apologise to Ms B for the failings identified
- b) pay £1500 redress, and
- c) review the case with the staff involved.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201504244 – Report issued in January 2017

Mr X complained, on behalf of his mother, Mrs Y, that Betsi Cadwaladr University Health Board's ("the Health Board") investigation of the care provided to his late father and her late husband, Mr Y, was unacceptably delayed and flawed. He complained that the Health Board failed to comply with what was required of it under The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Mr X was aggrieved that an investigation panel put together to investigate the events which led to Mr Y's death improperly included a Consultant who was involved in the events being complained about.

The Ombudsman found that the Health Board's investigation of the concerns raised about Mr Y's care had been unacceptably delayed and flawed and amounted to maladministration. The investigation also found that while the Health Board's handling of the complaint met, in many respects, the requirements of the Regulations, it also failed to meet significant requirements (particularly in relation to the timescales for responding). These failings caused Mr X and Mrs Y additional distress. With respect to the third issue, the Ombudsman found that it was inappropriate to include the Consultant on the panel and his inclusion may have detrimentally affected the outcome of that panel. Therefore, the three heads of complaint were upheld.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mr X and Mrs Y for the failings found
- b) offer a payment of £750 to reflect the additional distress caused by the poor complaint handling; and
- c) provide assurance regarding the procedures that were in place to ensure that concerns would be investigated in accordance with the Regulations and in a timely manner.

The Health Board agreed to implement the recommendations.

Betsi Cadwaladr University Health Board – Continuing Care Case Number 201504580 – Report issued in January 2017

Ms X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to properly consider her late mother's ("Mrs Y") eligibility for NHS Continuing Healthcare funding and that the conclusions reached about her ineligibility were unreasonable. Ms X's claim had been considered under the retrospective claim process and by an Independent Review Panel ("the Panel") convened by the Health Board.

The Ombudsman found that there were shortcomings in the process by which the decision was taken regarding Mrs Y's eligibility which amounted to maladministration. The Ombudsman found that there were significant omissions (mainly in the Needs Assessment but also the apparent improper absence of a 'Due Regard' Clinician to advise the Panel) which cast doubt on the robustness of the decision ultimately taken by the Panel. As a result, there was uncertainty as to whether the outcome of the process would have been different had those omissions and errors not occurred. The complaint was therefore upheld.

The Ombudsman recommended that the Health Board should:

- a) arrange a fresh assessment of Ms X's needs and should arrange another Panel (if that was necessary following the assessment), and
- b) undertake an audit of the Panels it had convened since 2015, with a view to establishing whether a 'Due Regard' Clinician had been improperly absent from any of those Panels, and report the findings to this office.

The Health Board agreed to implement the recommendations.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201505698 – Report issued in February 2017

Mr and Mrs D complained about the care Mr D received when he attended an Emergency Department ("ED") following a chest injury. Mr D later underwent emergency surgery. Mr and Mrs D complained about insufficient and/or delayed observations, investigations and monitoring, which led to a delay in diagnosis and treatment.

The investigation found areas of concern in Mr D's initial presentation which were not acted upon or escalated by the Emergency Department. The investigation also found shortcomings in the Emergency Department's record keeping which led to a delay in Mr D being reviewed by a Consultant. Recording and monitoring of Mr D's condition only became consistent when he deteriorated. Although Aneurin Bevan University Health Board ("the Health Board") had taken action in respect of record keeping and used Mr D's experience as a teaching case, the complaint was upheld on the basis that the failings identified left Mr and Mrs D with uncertainty as to whether Mr D's experience and outcome might have been different.

The Ombudsman recommended that the Health Board:

- a) should provide evidence of reminders given to staff of the importance of keeping full and accurate records
- b) undertake a dip sample audit across the ED to monitor and review the use of early warning charts
- c) provide evidence of the use of Mr D's experience as a teaching case, and
- d) ensure that training in the use of its early warning chart is up to date for all relevant staff.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201600854 – Report issued in February 2017

Mr A complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to diagnose the cause of his knee pain despite appointments with three separate Consultants. Mr A said that the Health Board also failed to consider that his pain was due to an injury/twisting motion and not due to arthritis/general degeneration. Mr A complained to the Health Board but was unhappy with the way that it managed his complaint.

The investigation found that Mr A's consultations with the three Consultants were appropriate, showed no evidence of injury to his knee, and that the cause of Mr A's symptoms was arthritis. The management and treatment of Mr A's knee would not have differed had his symptoms been those of an injury. The Ombudsman concluded that the care of Mr A's knee was reasonable. The complaint was not upheld. In respect of complaint handling, the Ombudsman found that the Health Board had made improvements to its processes following Mr A's first complaint but noted that he experienced a further delay when he raised further concerns. The Ombudsman concluded that the delay that Mr A experienced in receiving a response was unreasonable and upheld his complaint.

It was recommended that the Health Board should make a payment of £100 in recognition of the delay Mr A experienced. The Health Board agreed to implement the recommendation.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201506442 – Report issued in February 2017

Ms A complained about her late daughter, Ms B's management and care following a diagnosis of breast cancer at the Abertawe Bro Morgannwg University Health Board's ("the Health Board") Singleton Hospital in February 2013. Sadly, Ms B died on 14 October 2014.

The Ombudsman investigation did not find an unreasonable delay in Ms B being seen following her GP referrals and found that Ms B's treatment (plan) was in accordance with established clinical practice. There was also nothing to suggest that Ms B's mastectomy was not performed to an acceptable clinical standard. The Ombudsman did not uphold these aspects of Ms A's complaint.

The Ombudsman did identify shortcomings in terms of Ms B's pain management and the care around her cannula insertions. In addition, communication on the part of clinicians was not always as effective as it might have been. To that extent the Ombudsman upheld Ms A's complaint.

The Ombudsman's recommendations included the Health Board:

- a) apologising for the failings identified
- b) making a payment to Ms A of £750 on behalf of Ms B's daughter, and
- c) asking the clinicians to review Ms B's pain management and consider how her care might have been improved.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201600131 – Report issued in February 2017

Mrs B complained about the care received by her late husband during two inpatient admissions. Specifically, she complained about the failure/delay in diagnosis (malignancy and liver cirrhosis), failings in communication and nursing care, events surrounding a fall which Mr B sustained and the subsequent management of Mr B's head injury suffered in the fall. Mr B died later the same day from a subdural haemorrhage.

The Ombudsman found that there were failings in Mr B's care during his first admission: no investigations were carried out to establish the cause of Mr B's symptoms and there were failings in communication both between professionals and with Mr B's family. The failings in communication continued during his second admission, which meant that Mr B's family did not appreciate how ill he was, and Mrs B's wishes regarding resuscitation were not ascertained early enough, resulting in a distressing telephone conversation. Whilst the Ombudsman did not criticise Cardiff and Vale University Health Board ("the Health Board") in respect of Mr B's fall, neurological observations had not been carried out in accordance with guidance, and the resuscitation team was not called as promptly as it should have been. Nevertheless, earlier identification of Mr B's head injury would not have changed the outcome.

The Ombudsman upheld Mrs B's complaint, and recommended it:

- a) apologise to Mrs B

- b) make a payment of £750 in respect of the distress caused by the failings identified
- c) provide evidence that the Health Board had carried out the recommendations of its own investigation, as well as reminding clinicians of the importance of communication.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201505027 – Report issued in February 2017

Mr M complained about the care and treatment that his late aunt, Mrs A, received during her admission to The Princess of Wales Hospital (“the hospital”) between 30 April and 9 May 2014. Mrs A underwent major surgery to remove a cancerous growth from her colon but sadly passed away at home some four days after her discharge. A post mortem revealed that the reconnected ends of the intestine had leaked, resulting in an abscess that subsequently ruptured, causing peritonitis. Mr M complained that:

- The leak occurred as a result of poor surgical technique
- Clinicians failed to pursue suspicions that a leak may have occurred by carrying out a CT scan
- Mrs A’s discharge was premature and unsafe and the information provided to her GP was insufficiently detailed
- The Health Board (initially) failed to provide Mr M with a formal complaint response under PTR regulations.

The Ombudsman, assisted by his Clinical Adviser, found no evidence of poor surgical technique, but upheld Mr M’s complaint that clinicians failed to conduct a CT scan. The Ombudsman was unable to conclude that a scan would have prevented Mrs A’s demise and death, but he considered that the uncertainty surrounding this matter was in itself an injustice to the family. The Ombudsman found no evidence that Mrs A’s discharge was unsafe, but did find that the Abertawe Bro Morgannwg University Health Board’s (“the Health Board”) handling of Mr M’s complaint did not adhere to PTR regulations.

The Ombudsman recommended that:

- a) the Health Board provide a written apology to Mr M
- b) in recognition of the distress caused to the family, make a payment to him of £500
- c) colorectal clinicians at the Hospital should familiarise themselves with recent clinical guidance regarding the management of suspected post-surgical leakage and should provide evidence to the Ombudsman that this has been done.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201602061 – Report issued in February 2017

Mrs B complained that Betsi Cadwaladr University Health Board (“the Health Board”) had failed to identify the cause of the swallowing difficulties her late husband was experiencing. In particular, she considered

that his Surgeon should have arranged either a biopsy or CT scan after a Barium Swallow test had failed. This did not happen and less than three months later Mr B was diagnosed with lung cancer which led to his death. Mrs B also considered that Mr B's Surgeon did not take appropriate account of the concerns Mr B had raised about the weight loss he was experiencing.

The Ombudsman found that Mr B should have received a CT scan after the barium swallow test had failed. He accepted however that a biopsy was not appropriate given Mr B's state of health. He also found that it was highly unlikely that even if a CT scan had been performed earlier it would have had any impact on Mr B's outcome

With regard to taking appropriate account of Mr B's weight loss, the Ombudsman was unable to conclude that the Surgeon had acted inappropriately given that he was aware that at the time of his weight loss Mr B was participating in a diet programme.

The Ombudsman upheld the complaint relating to a failure to arrange a CT scan because of the uncertainty Mrs B faced as to whether earlier, more appropriate, investigations would have given Mr B a better, albeit very slim, chance of a different outcome. He recommended that the Health Board

- a) apologise to Mrs B, and
- b) provide her with redress of £500.

A Pharmacy in the area of Aneurin Bevan University Health Board -Clinical treatment outside hospital Case Number 201602440 – Report issued in February 2017

Mrs X complained that a Pharmacy ("the Pharmacy") in the area of Aneurin Bevan University Health Board ("the Health Board") dispensed incorrect medication to her father, Mr Y, on two occasions.

The Ombudsman upheld the complaint. He found that both errors happened as a result of a failure to follow and correctly apply the Pharmacy's policy.

The Ombudsman recommended that the Pharmacy should:

- a) provide redress to the patient
- b) ensure that relevant staff have read and understood the Pharmacy's policy and signed the document to show that they have done so, and
- c) review its policy.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201600768 – Report issued in February 2017

Mrs C complained about the care her brother, Mr D, received during two periods of hospitalisation before he sadly died in October 2014. Mrs C said his needs were not adequately assessed, a decision to give radiation therapy was not in his best interests, Mental Health care was not adequate and a DNAR (Do Not Attempt Resuscitation) decision was not communicated with Mr D's family. Mrs C also complained about

the way her complaint was handled.

A number of aspects of the complaint were upheld. There was evidence that Mr D's needs were not properly assessed or that assessments were not updated when there were relevant changes to his condition, the Mental Health care provided to Mr D was unreasonably delayed and the DNAR decision was not adequately documented and did not involve Mr D's family. The investigation also found that the complaint handling was poor. The Ombudsman did not uphold the complaint that the decision to give radiation therapy was not in Mr D's best interests but was concerned about the way the decision was documented.

Cwm Taf University Health Board ("the Health Board") agreed to:

- a) apologise to Mrs C
- b) pay £1250 in recognition of the distress caused by the failings identified and the time and trouble taken to pursue the complaint because of the delays in complaint handling, and
- c) audit the ward's discharge procedures and DNAR documentation and to provide training to staff on updating risk assessments.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201505562 - Report issued in February 2017

Mrs B complained about the care and treatment that her daughter ("Ms R") received at the Maternity Unit at Nevill Hall Hospital ("the Hospital") in the period leading up to the delivery of her stillborn baby girl ("baby M") in 2014. In particular, Mrs B said that when they contacted the Maternity Unit for help and advice on 4 January they were "put off" attending as it was busy. Mrs B believed that had her daughter been advised to attend then monitoring would have highlighted that baby M was distressed. This would have led to appropriate action being taken and the outcome being different.

The Ombudsman's investigation concluded that there was a failure to rule out the possibility that Ms R's membranes might be ruptured. He was also critical that carrying out a vaginal examination without first excluding ruptured membranes was inappropriate as it risked introducing infection. He was also critical that when it was identified by clinicians that baby M had died Ms R was allowed to remain in labour for almost five and a half hours before she received an epidural. These aspects of Mrs B's complaint were upheld.

The recommendations that the Ombudsman made included Aneurin Bevan University Health Board:

- a) apologising to Mrs B and through her paying Ms R the sum of £750 in recognition of the distress caused to her as a result of the shortcomings in care
- b) ensuring that the guidelines issued by the Royal College of Obstetricians and Gynaecologists (on ruptured membranes and pain management) were brought to the attention of its midwifery and medical staff.

Betsi Cadwaladr University Health Board- Clinical treatment in hospital Case Number 201601660 - Report issued in February 2017

Miss N complained about functional endoscopic sinus surgery ("FESS") which she underwent in March 2014 at Ysbyty Glan Clwyd. Miss N was concerned that this procedure might have gone wrong, causing complications which required further surgery and which she was concerned might have caused her to have ongoing health problems. She was also concerned about what she was told about the risks of the operation beforehand and that communication with her afterwards about what happened was inadequate.

The Ombudsman found that Miss N had suffered an extremely rare, but known, complication of FESS when the thin bone between the sinus and the orbit of her right eye was pierced during surgery. However, the evidence did not suggest that this occurred due to poor practice on the part of the Surgical team. The Ombudsman also concluded that, on balance, the communication with Miss N after the event was likely to have been adequate. He did not uphold these parts of the complaint. He upheld the complaint that Miss N was not given adequate information about the risks beforehand; in particular there was no evidence that the complication Miss N suffered was mentioned to her.

The Ombudsman recommended that the Health Board:

- a) apologise to Miss N, and
- b) provide a written reminder to staff involved in the consent process for FESS of the need to mention the risk of orbital complications and record that on the consent form.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201600123 - Report issued in February 2017

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to diagnose lobular breast cancer in her left breast in May 2014. Mrs X also complained about the manner of the Consultant Breast Surgeon ("the First Consultant") during her outpatient appointment in September. Mrs X complained about the strict application of departmental policy regarding MRI scans for breast cancer. Mrs X also complained about the delay in complaints handling.

The Ombudsman found that whilst Mrs X did not meet the criteria for an MRI scan in May, she did in September. Had the scan been carried out at that time, on the balance of probabilities, the cancer would have been detected. The Ombudsman partially upheld the complaint. The Ombudsman did not find evidence that the First Consultant failed to understand Mrs X's concerns during the consultation in September. The Ombudsman did not agree that the departmental policy regarding MRI scanning should be flexibly applied; he noted that the Health Board was unable to do so and that providing scans for reassurance purposes is not always helpful. The Ombudsman upheld the complaint about delay in complaints handling, as the response took six months to be received.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs X
- b) offer her a payment of £550 in respect of the anxiety caused by the delay in the MRI scan and the

delay in the complaint response

- c) make all relevant staff aware of the need to adequately document discussions regarding MRI scanning for breast cancer at MDT meetings
- d) review the Guidelines and consider adding further clarification to the particular criteria that applied in this case, and
- e) remind all relevant clinical and radiology staff about how it considers the Guidelines for MRI scanning of breast cancer patients should be interpreted.

The Health Board agreed to implement the Ombudsman's recommendations.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201603066 - Report issued in February 2017

Mrs X complained about the care and treatment provided to her husband Mr X by Abertawe Bro Morgannwg University Health Board ("the Health Board") when he was an inpatient at Princess of Wales hospital between February and September 2013. In particular, Mrs X complained about Mr X's peri-prosthetic infection (an infection surrounding the metal of which the hip prosthesis was made) and how this occurred, the gap in Mr X's medical records and whether Mr X was suffering from opioid toxicity (when a patient has taken too much of an opioid drug) between these dates, whether his leukaemia and pressure sore were adequately treated and the failings in Mr X's oral care and whether these had been acted upon. Mrs X also complained about the delayed handling of her complaint by the Health Board.

The Ombudsman found that there was no evidence that the Health Board's actions contributed to Mr X's peri-prosthetic infection. There was no evidence that Mr X was suffering from opioid toxicity and the Ombudsman was satisfied that Mr X's leukaemia was appropriately treated. The Ombudsman found that Mr X's oral care was not inappropriate and that his pressure sore was adequately treated. He did not uphold the complaints. The Health Board's complaint investigation took over a year to be completed and the Ombudsman upheld Mrs X's complaint in this regard. He recommended that the Health Board pay Mrs X the sum of £250 in recognition of the Health Board's delay and apologise to her.

The Health Board accepted the recommendation.

A GP Practice in the area of Aneurin Bevan University Health Board – Clinical treatment outside hospital Case Number 201603301 - Report issued in February 2017

Ms X complained that home visits were requested for her mother, Mrs X, on 9 and 11 February 2015 but doctors from the GP Practice ("the Surgery") did not attend. Ms X said that opportunities were missed to diagnose Mrs X with bronchopneumonia. Ms X said that had this diagnosis been made, Mrs X might have survived but if not, the family would have had an opportunity to say goodbye. Ms X said that a post mortem was required when Mrs X passed away. Due to the time this took, the family were unable to visit Mrs X in the funeral home.

The Ombudsman found that a home visit should have been made on 11 February. Had a doctor from the

Surgery visited Mrs X, she might have been showing symptoms of bronchopneumonia and might have been referred for further treatment. He partially upheld the complaint. The Ombudsman found it likely that a post mortem would have been required in any event and this was not due to any failing on the part of the Surgery. He did not uphold the complaint.

The Ombudsman recommended an apology be made to Ms X. He recommended a reminder be issued to all Surgery staff to state their name and job title when telephoning patients. The Ombudsman recommended that the system for requesting home visits be reviewed and that waiting times for calls requesting visits be audited and improvements made, if necessary. The Surgery should reflect on whether doctors in their second year after qualifying should carry out triage of patients requesting home visits.

The Surgery agreed to implement the Ombudsman's recommendations.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number 201505392 - Report issued in February 2017

Mrs G complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to respond to her complaint about her adult daughter's care at Singleton Hospital, Swansea, in July and August 2015. She also complained that the Health Board failed to carry out an assessment of her daughter's eligibility for NHS continuing care ("CHC") funding and that this had meant she was not receiving an adequate level of support.

The Ombudsman upheld the complaint about the Health Board's response to Mrs G's complaint as it had taken nine months to provide an interim response. However, the Ombudsman did not make any recommendations to the Health Board as it had already apologised and offered appropriate financial redress of £250. The Ombudsman did not uphold the complaint about the CHC funding as it was apparent that the family had not been keen to pursue a CHC assessment due to the restrictions it could potentially place on Ms G's care package. In particular, the family had wanted direct payments, which are not possible under CHC funding arrangements.

Aneurin Bevan University Health Board and a GP Practice in the area of the Health Board Case Numbers 201505394/201600658 - Report issued in February 2017

Mrs A complained about a GP Practice ("the Practice") and Aneurin Bevan University Health Board ("the Health Board"). Mrs A's complaint about the Practice related to the care her mother ("Mrs B") received from the GPs between 28 July and 8 September 2014. This included a failure to refer her mother to the Pain Clinic and review her potassium levels on 5 September. In relation to the Health Board, Mrs A was unhappy with the care her mother received while an inpatient at the Royal Gwent Hospital ("the Hospital") between 27 August and 9 September 2014. Mrs A also complained about the Health Board's handling of her complaint.

The Ombudsman's investigation concluded that broadly the care provided by the GPs was reasonable and appropriate. However administratively, he found shortcomings in record keeping and a failure to review Mrs B's blood test result on 5 September and upheld this aspect of the complaint.

In relation to Mrs B's care in the Hospital, again the investigation found no shortcomings in care. However, the Ombudsman was critical that clinicians had not communicated with Mrs A when her mother's condition

deteriorated. He was also critical about the Health Board's handling of Mrs A's complaint. These aspects of Mrs A's complaint were upheld.

The Ombudsman recommended that both the Health Board and the GP Practice apologise to Mrs A for the failings identified by the Ombudsman's investigation and for the Health Board to pay her a sum of £300 for the poor complaint handling.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201600459 – Report issued in March 2017

Mrs L complained about the care her late husband ("Mr L") received on a respiratory ward at Cwm Taf University Health Board ("the Health Board"). Mrs L complained that the Health Board failed to identify and treat Mr L's symptoms of hydration, that the removal and management of his tracheostomy was contrary to his care plan and that the administering of his medication was contrary to his care plan. Mrs L also complained that the Health Board did not manage or investigate her concerns appropriately.

The Health Board accepted that there had been some shortcomings in relation to medication and the removal of the tracheostomy.

The Ombudsman found that there had been shortcomings in the Mr L's care and the Health Board's management of Mrs L's complaint. The Ombudsman upheld the complaint and made recommendations in respect of hydration, administering medication, record keeping and complaint handling.

The Health Board accepted the recommendations and the Ombudsman was pleased to note the additional action it was taking to address Mrs L's complaint.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number 201506004 – Report issued in March 2017

Mr Y complained about shortcomings in his management and care at the Cwm Taf University Health Board's ("the Health Board") Royal Glamorgan Hospital which led to delays in a deep vein thrombosis ("DVT") being diagnosed, despite his presenting symptoms. He was also dissatisfied with the Health Board's handling of his complaint.

The Ombudsman's investigation found that Mr Y's clinical management was reasonable and did not uphold his complaint.

Administratively, the Ombudsman found unacceptable delays in complaint handling which the Health Board had previously acknowledged. In addition, the Ombudsman established that the Health Board's investigation had not been sufficiently robust. Mr Y's complaint was upheld.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr Y for the administrative failings identified
- b) make a payment in recognition of the failings of £350 and

- c) review the events that led to a letter with incorrect clinical information being sent to a GP.

The Health Board was asked to notify the Ombudsman of any additional measures it intended to put in place as a result of what had happened.

**A GP Practice in the area of Abertawe Bro Morgannwg University Health Board and Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital
Case Numbers 201600705 / 201600727 – Report issued in March 2017**

Mr M's complaint related to his late wife's management and care and the failure to make a breast cancer referral sooner, despite her reporting a breast lump on 2 April to the Locum Doctor at the GP Practice. Mr M also questioned whether his wife's medical records had been altered, given that there was no reference to the lump in the consultation notes. Finally, he was dissatisfied with the way that Abertawe Bro Morgannwg University Health Board ("the Health Board") had dealt with their GP complaint.

The Ombudsman found that the management and care Mrs M received from the GP Practice was reasonable and did not uphold this part of Mr M's complaint.

In terms of the Health Board, the Ombudsman noted it had sought assistance from an external IT provider which had identified no evidence of the records being altered. The Ombudsman did identify that communication was an issue when it came to the Health Board's handling of Mr and Mrs M's complaint and upheld this part of Mr M's complaint.

The Health Board was asked to:

- a) apologise, and
- b) make a payment of £350 in recognition of the impact that the administrative failings had on Mr M's wife.

**Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number 201600366 – Report issued in March 2017**

Mrs X complained about the care and treatment that her son, Mr Y, received at Wrexham Maelor Hospital in December 2013. Mr Y is an adult with physical and learning disabilities. Mrs X complained that:

- a) Her son's care plan was inappropriate
- b) A Do Not Attempt Resuscitation ("DNAR") order was not appropriately managed
- c) The management of Mr Y's medication, fluid and nutrition was unsatisfactory.

Mrs X also complained about Betsi Cadwaladr University Health Board's ("the Health Board") complaint response.

The Ombudsman, taking account of clinical advice found that Mr Y's overall clinical care was not unreasonable however he identified a number of shortcomings in specific areas. The Ombudsman did not

uphold Mrs X's complaint that her son was on a pathway that restricted his fluid and led to dehydration. However he did uphold that the care plan had been inadequately developed with limited planned senior medical oversight. The Ombudsman also found that although it was not unreasonable to seek to have a DNAR order in place over a particular weekend, there were shortcomings in the way it was dealt with and to the extent of those he upheld this element of the complaint. The Ombudsman found nothing to suggest that the management of nutrition and medication had been unreasonable. However, with regard to fluid management he was concerned about the record keeping and partly upheld the complaint.

Finally, the Ombudsman also partly upheld Mrs X's concern about the Health Board's responses to her complaint.

The Ombudsman made a range of recommendations including that the Health Board:

- a) issue an apology to Mrs X
- b) provide £1,250 financial redress for the distress caused and for the time and trouble incurred, and
- c) further actions including learning for staff and an audit to improve clinical practice.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201601670 – Report issued in March 2017

Mrs Y complained on behalf of her husband (Mr Y) about the care and treatment that he received in the Emergency Department ("ED") at Ysbyty Glan Clwyd on 22/23 March 2015. She said that Mr Y was left on an examination bed for over eight hours; that his diabetes was not appropriately dealt with and that Mr Y was misdiagnosed. Mrs Y also complained about the management of her concerns.

Taking account of clinical advice, the Ombudsman was of the view that the care provided to Mr Y was not in the main unreasonable; however there were shortcomings. The Ombudsman found it was unsatisfactory that Mr Y had to wait two hours from registration before being triaged by nursing staff and that he incurred a further significant delay before being assessed by a doctor. Fortunately the eventual outcome was that Mr Y did not have a serious illness but the Ombudsman was of the view that Mr Y may have suffered unnecessarily prolonged uncertainty during his time in ED and was likely to have experienced physical discomfort by being on an examination bed for a long period.

The Ombudsman found that the recording of Mr Y's pain was also insufficient. To the extent of the above concerns he upheld the complaint. Similarly the Ombudsman upheld Mrs Y's concerns about Betsi Cadwaladr University Health Board's ("the Health Board") complaint response. The Ombudsman did not uphold the complaint that Mr Y's diabetes was not appropriately dealt with, nor did he uphold the complaint that Mr Y had been misdiagnosed.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr and Mrs Y
- b) provide a redress payment of £500 for the shortcomings identified

- c) review its policies and staffing of ED, and
- d) provide evidence to the Ombudsman of monitoring and improvement.

Aneurin Bevan University Health Board - Confidentiality Case Number 201602418 – Report issued in March 2017

Mrs A complained about issues which arose during her aunt, Mrs B's, stay at two hospitals in Aneurin Bevan University Health Board's ("the Health Board") area. She said that the Health Board failed to provide appropriate interpretation facilities for Mrs B, who is deaf; she also complained that information about Mrs B had been given to a third party she had specifically requested should not have such information, and despite a password being put on her records to prevent this happening.

The Ombudsman upheld the complaint. He found that, although a sign language interpreter was provided for Mrs B on two occasions, when her consent was required for surgery, there was no plan for communicating with Mrs B, no record of the information contained in notes the Health Board said were passed to her, and no evaluation of the effectiveness or appropriateness of this. The Ombudsman also found that there had been some confusion over the existence of the password on Mrs B's records, although he could not determine how the third party came to know the password.

The Health Board had already addressed the issue of communication with people with sensory loss, and the use of the password system. The Ombudsman therefore recommended that the Health Board apologise to Mrs A and Mrs B.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201505839 – Report issued in March 2017

Ms D complained about the care and treatment that her elderly mother, Mrs M, received at Ysbyty Ystrad Fawr following her admission for investigations of unexplained seizures and confusion. Ms D complained that during the admission clinicians failed to fully assess Mrs M's confusion and failed to refer her to the physiotherapy service. Ms D also complained that Mrs M fell on two occasions during her admission and sustained severe bruising. Ms D suggested that these falls were preventable and came about as a result of the failure of nurses to promptly respond to Mrs M's call bell. Finally, Ms D complained that clinicians were slow to investigate and treat a DVT that Mrs M developed in her lower right leg.

The Ombudsman upheld Ms D's complaint that clinicians did not adequately assess Mrs M's confused condition and failed to refer her to hospital-based mental health professionals.

The Ombudsman also partially upheld Ms D's complaint that there was a short delay in nurses escalating Mrs M's reports of pain in her lower leg. However, the Ombudsman concluded that the call bell response time was not a contributing factor to Mrs M falls and that nurses took steps to prevent her from falling as far as was possible. The Ombudsman was also satisfied that Mrs M did receive appropriate physiotherapy.

The Ombudsman recommended that Aneurin Bevan University Health Board:

- a) provide Ms D with a fulsome apology and a payment of £300

- b) remind clinicians of the importance of involving mental health professionals in assessing patients with confusion, and
- c) provide an update on an Action Plan that it instigated in response to the family's complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201504952 – Report issued in March 2017

Mrs A complained to the Ombudsman about a failure by the Health Board to identify that her mother (Mrs B) had sustained a fracture of her arm following her admission to Ysbyty Gwynedd. She complained that it failed to identify extensive bruising to her mother's arm despite two bed washes and review by nursing and clinical staff. She also complained that Mrs A was discharged with an incorrect sling and without a follow-up appointment in clinic. She was also dissatisfied with the delays she experienced in receiving a response to her concerns.

The Ombudsman was unable to determine how, when or where Mrs B sustained her fracture but acknowledged that it may have been caused by a seizure. He did find however that there had been a delay in identifying the bruising, although this delay may have been as short as four hours. However, given that a conservative treatment plan was followed when the fracture was identified, the treatment Mrs B would have received if the fracture had been identified earlier would not have been different. The Ombudsman upheld this aspect of the complaint in part.

With regard to the failures identified when Mrs B was discharged, the Ombudsman found that there had been no outstanding detriment to Mrs B as a result of these failures and considered that the Health Board's apology for the errors addressed these matters sufficiently and he did not uphold these complaints. The Ombudsman did however find failings in the manner in which the Health Board had responded to Mrs A's complaint and recommended that the Health Board:

- a) apologise, and
- b) pay her redress of £250 and review the measures it was taking to deal with complaints.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201601404 – Report issued in March 2017

Mrs G complained to the Ombudsman on behalf of her son, Mr D, that Betsi Cadwaladr University Health Board ("the Health Board") had discharged him from A&E inappropriately. She believed that the Health Board had assumed that his vomiting, headache and disorientation had been as a result of excessive alcohol consumption and not because of the head injury he had experienced.

Mr D collapsed at home the day after his discharge and upon further investigation was found to have bleeding on the brain which resulted in him being transferred immediately to a specialist neurosurgery centre.

Mrs G was dissatisfied that the Health Board, whilst acknowledging failures in its duty of care towards Mr D, was of the view that there was no qualifying liability. The Ombudsman accepted the Health Board's view

that there had been failings in the way it had discharged Mr D, but agreed that despite this inappropriate discharge, it would not have been appropriate to have actively treated Mr D and that as a consequence the clinical outcome would not have been different.

The Ombudsman concluded that the events Mr D experienced immediately following his discharge would have caused him distress and inconvenience and therefore recommended the Health Board:

- a) apologise and provide him with redress of £300, and
- b) take action to address the shortcomings it identified in the manner it discharged Mr D.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital **Case Number 201504895 – Report issued in March 2017**

Mrs X and Mrs Y complained that Betsi Cadwaladr University Health Board (“the Health Board”) had, through its own investigation, found shortcomings in the care provided to Mrs Y’s husband, Mr Y, during the last days of his life at Ysbyty Gwynedd but subsequently failed to properly address those. They said that the Health Board’s continued failure to address those shortcomings caused them additional distress.

The investigation found that whilst the Health Board provided information about the actions it said it had taken to address those shortcomings, it failed to provide persuasive documentary evidence to demonstrate that those actions had been robustly undertaken. That failure to demonstrably address the failings found amounted to maladministration on the part of the Health Board. The complainants were caused additional distress by the Health Board’s apparent lack of action in respect of the failings found. To that extent, therefore, the complaint was upheld.

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

- a) apologise to the complainants, and
- b) provide assurance that a mechanism was in place to ensure that documentary evidence was retained of any formal training undertaken by staff at the Hospital in respect of the healthcare it provided to the public.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital **Case Number 201601599 - Report issued in March 2017**

Ms A complained about the care and treatment her late mother, Mrs B, received at Wrexham Maelor Hospital in February 2015. In particular, Ms A was concerned that her mother’s symptoms were not identified and treated as soon as they should have been and that as a result her mother sadly died from sepsis.

Mrs B attended the hospital on two occasions within the space of 48 hours. Whilst Mrs B was correctly admitted on the second occasion and given appropriate treatment, the Ombudsman was critical of the fact Mrs B was sent home on the first occasion. The Ombudsman found that there were sufficient indicators of concern at Mrs B’s first attendance to have justified blood tests, which would likely have identified sepsis.

Treatment could then have started at an earlier stage. The Emergency Department ("ED") Doctor's note of his assessment on the first visit was inadequate and did not include details of what the rationale for discharge was or what Mrs B and her family were told.

The Ombudsman recommended that the Betsi Cadwaladr University Health Board:

- a) apologise to the family
- b) pay them £2,500 in recognition of the uncertainty of whether the outcome may have been different had treatment been started sooner
- c) remind the ED Doctor of the need to fully document his assessments
- d) remind ED triage nurses be reminded of the need to flag potential sepsis patients following triage, and
- e) review the management of sepsis and suspected severe sepsis at the ED.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201600431 - Report issued in March 2017

Mrs A complained about Mr A's appendectomy surgery, inadequate pain relief and inappropriate discharge from hospital. As a result Mr A was re-admitted to hospital the day after his discharge with an infected surgical wound, for which he underwent further surgery.

The investigation found that Mr A's appendectomy surgery was within acceptable clinical practice, and he had received appropriate pain relief. However, the Ombudsman found Mr A's discharge may have been inappropriate, but there was no evidence that his discharge and his subsequent re-admittance to hospital had a significant impact on his clinical outcome or recovery. The Ombudsman partly upheld Mrs A's complaint limited to the extent that the distress and uncertainty caused by Mr A's discharge had affected them.

The Ombudsman recommended Betsi Cadwaladr University Health Board apologise to Mr and Mrs A for the distress and uncertainty caused to them by the affects of his discharge.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201506656 – Report issued in March 2017

Mrs A's complaint concerns the care and treatment she received from a Consultant Surgeon ("the Surgeon") at Wrexham Maelor Hospital, ("the Hospital") following a diagnosis of vaginal cancer. Mrs A also had concerns about poor communication and Betsi Cadwaladr University Health Board's ("the Health Board") handling of her complaint.

The Ombudsman found that the overall clinical care that Mrs A received from the Surgeon was reasonable. This aspect of Mrs A's complaint was not upheld.

The Ombudsman did identify aspects of Mrs A's care that could have been improved. He was concerned about the events that led to Mrs A being put on the waiting list for closure of a stoma. This had increased her expectation that it would be reversed when it was not clinically appropriate. Additionally, he identified that a hernia support, which would have alleviated some of Mrs A's discomfort, should have been provided sooner than it was. To that extent the Ombudsman upheld this part of Mrs A's complaint.

The Ombudsman found communication both in terms of Mrs A's follow up care and management and from a complaints handling perspective could have been better. These aspects of Mrs A's complaint were upheld.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs A for the shortcomings identified
- b) pay her the sum of £750 for the distress and inconvenience caused to her, and
- c) remind its surgical clinicians of their duty to conduct and record pre-operative consent processes in accordance with the General Medical Council's guidance.

The Health Board was asked to share a copy of the Ombudsman's report with the Chair of the Health Board and the Patient Safety and Clinical Governance Group.

NOT UPHELD

A GP Practice in the area of Cwm Taf University Health Board – Clinical treatment outside hospital Case Number 201506891 – Report issued in January 2017

Mrs M complained that despite her plasma viscosity level being raised between 2013 and July 2015 when she suffered a stroke, the GPs at the Practice took no action in response to her abnormal blood test results and provided no explanation for the results. Mrs M was of the opinion that, had the Practice carried out further investigations, she may not have suffered a stroke.

The Ombudsman found that the Practice provided a reasonable standard of care in relation to the plasma viscosity blood test results. He also found that there was no plausible association between the marginally raised plasma viscosity blood test results (these were just outside the normal range) and the development of a stroke. The Ombudsman did not uphold the complaint.

The Ombudsman identified some concerns around complaints handling and Cwm Taf University Health Board agreed to liaise with the Practice to address these issues.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201602400 - Report issued in January 2017

Mrs A complained about the treatment her mother, Mrs B, received at Morriston Hospital and about the way staff communicated with her father, Mr B. She complained that her mother was allowed to become dehydrated and that doctors kept asking her father if he knew what was wrong with her.

The Ombudsman found that there were some shortcomings in the monitoring of Mrs B's fluid intake and output. However, he concluded that the dehydration she experienced came as a result of her complex

clinical condition and the more clinically important need to remove fluid from her lungs. The Ombudsman also found that conversations with Mr B had been intended to ensure that he understood the seriousness of his wife's condition. The Ombudsman did not uphold the complaints.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201603217 - Report issued in January 2017

Ms X complained that Hywel Dda University Health Board ("the Health Board") provided her with incorrect medication for a urine infection whilst pregnant. Ms X said that this medication caused her membranes (waters) to break too early, which led to the sad death of her son.

The investigation found that Ms X was not suffering from an infection immediately before or at the time her son was born. She was, however, given appropriate antibiotics for pre term rupture of membranes (the waters breaking before 37 weeks' gestation. If this happens, it can trigger early labour) on 12 January. It was likely that the pre term rupture of membranes caused the sad death of Ms X's son.

There was no evidence to suggest that the Health Board took any action or failed to take any action which could have been connected to the sad death of Ms X's son.

The Ombudsman did not uphold the complaint.

A Dental Practice ("the Practice") in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital

Case Number 201505913 – Report issued in January 2017

Mrs X complained that in 2015 a Dentist ("the Dentist") at the Practice failed to properly examine and care for her young son, Child X, which led to him requiring the extraction of six teeth. Child X was seen by the Dentist in August, when it was recorded that there was no tooth decay. In November, another dentist saw Child X and recommended that six teeth should be extracted because of tooth decay.

The investigation found that the care provided by the Dentist during the appointment in August appeared to have been of a reasonable standard. Furthermore, it was found that it was possible that sufficient decay could have happened between the two appointments to justify the removal of the six teeth, even if there had been no evidence of tooth decay in August. The complaint was not upheld.

A Dental Practice within the area of Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital

Case Number 201600876 – Report issued in February 2017

Ms F complained that following Orthodontist advice in 2012 the Dental Practice failed in its management and care of her un-erupted tooth. Ms F said that this failure led her to experience pain and further issues with her teeth which resulted in oral surgery. Ms F said that her surgery was avoidable and that she had experienced emotional stress.

The investigation found no evidence of any changes to the un-erupted tooth or changes caused to any other teeth as a result of the un-erupted tooth. The investigation also found no reason for the Dental Practice to have departed from the advice received in 2012. The Ombudsman concluded that the Dental Practice's care was reasonable and that it acted in accordance with accepted practice in its management of the un-erupted tooth. The complaint was not upheld.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201603360 – Report issued in February 2017

Mr X said that Cardiff and Vale University Health Board (“the Health Board”) should have offered him surgery in 2012 to address his sinus problems, instead of offering it in 2015, following a second opinion. Mr X complained that he had experienced avoidable symptoms as a result of the Health Board’s failure to consider surgery in 2012, because his airways became clearer following surgery in 2016.

The investigation found that the care and management of Mr X’s sinus concerns in 2012 was appropriate and in accordance with acceptable practice. The investigation also found that there was nothing to suggest that Mr X’s situation had deteriorated between 2012 and 2015 which would have required surgery. The complaint was not upheld.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number 201601463 – Report issued in February 2017

Mr X sustained injuries in a road traffic accident in March 2011. He complained that Cardiff and Vale University Health Board (“the Health Board”), over the course of the following three years, failed to undertake appropriate investigations of his ongoing symptoms and failed to make a timely referral to a vascular clinic. Mr X said that when he underwent emergency surgery in November 2014 to bypass a blocked artery and to remove a blood clot from his right leg his symptoms had disappeared, and he therefore believed they had been of a vascular nature.

The Ombudsman found that Mr X had a number of investigations between 2011 and 2014 to try to establish the cause of his pain, and a range of interventions intended to help. There was no suggestion of a vascular problem at any of the consultations, as Mr X’s complaints related to back pain and not pain radiating to the lower leg. He concluded that the investigation and management of Mr X’s condition between 2012 and 2014 was appropriate, and he did not uphold the complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201504617 – Report issued in February 2017

Mrs R complained about the way in which Aneurin Bevan University Health Board (“the Health Board”) managed the lung cancer diagnosis, which it made in respect of her mother, Mrs S. Mrs R said that the Health Board did not obtain all of the necessary clinical information before making this diagnosis and giving a devastating prognosis to her. She reported that it did not support Mrs S appropriately when it became apparent that her lung cancer diagnosis was incorrect. She stated that it also failed to treat Mrs S’s chest-related symptoms properly because of that ‘misdiagnosis’.

The Ombudsman found that the clinical information that the Health Board had acquired, before making its presumptive lung cancer diagnosis, in respect of Mrs S, was sufficient. He determined that this diagnosis did not compromise the Health Board’s treatment of Mrs S’s chest-related symptoms. He also found that its response to the change in Mrs S’s diagnosis was reasonable. He did not uphold Mrs R’s complaint.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201600910 - Report issued in February 2017

Ms T complained that Cardiff and Vale University Health Board’s (“the Health Board”) Community Mental

Health Team (CMHT) had failed to provide her with a Care and Treatment Plan (CTP) following her discharge from hospital, and failed to engage with her as a patient and include her in discussions relating to her care.

The Ombudsman found that Ms T's CTP had been commenced; however it was never shown to Ms T or her agreement sought. This element of the complaint was partly upheld as the CMHT had failed to record the rationale for withholding the CTP from Ms T. The Ombudsman did not find a failing on the part of the Health Board to engage with Ms T as a patient and therefore this aspect of the complaint was not upheld.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201601026 – Report issued in February 2017

Mrs F complained about the care and treatment provided to her late father, Mr G, by Aneurin Bevan University Health Board ("the Health Board") between 16 and 18 February 2016. In particular:

- Mr G should have been prescribed prednisolone (a steroid medication, used to treat breathing problems);
- Mr G was administered a high dose of iron which contributed to his death.

The complaints were not upheld on the basis that the care and treatment provided to Mr G by the Health Board was reasonable and did not cause him harm.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201602204 – Report issued in February 2017

Mrs B complained that in June 2015 Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to investigate, diagnose and treat a displaced fracture of the radial head (the top of the radius bone, in the forearm, where it meets the elbow). She also said that her complaint to the Health Board was not properly investigated.

The investigation found that the radial head fracture, which was difficult to spot, was missed but the treatment, for a sprain, is the same as the treatment for a radial head fracture therefore no injustice arose from this therefore the complaint was not upheld.

The Health Board provided a reasonable, thorough and timely response to Mrs B. Therefore this complaint was not upheld.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201505980 – Report issued in February 2017

Mrs X complained that informed consent was not obtained from her before surgery was undertaken in October 2015. She said that she was not properly made aware of, among other things, the associated post operative risk of infection. Mrs X saw a Consultant Surgeon about issues she had with vaginal scar tissue which was susceptible to splitting and was thought, therefore to be at risk of infection. A Fenton's procedure was planned (i.e. an operation to remove scar tissue and widen the vaginal opening) to resolve the issue. The procedure was undertaken the next day. Mrs X said that she suffered from complications

following the operation.

The investigation was unable to reach a finding as to whether informed consent had been obtained in this case because the irreconcilable and conflicting evidence obtained was so finely balanced. Therefore the Ombudsman did not uphold the complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number 201604160 - Report issued in February 2017

Mr X complained about the care and treatment provided to his mother, Mrs X, following a hernia repair and small bowel resection operation at Nevill Hall hospital on 19 May 2015. Mr X said that had Mrs X been placed on a surgical ward, she would have received a higher standard of nursing care. Mr X said that Aneurin Bevan University Health Board ("the Health Board") provided Mrs X with the wrong type of food on 20 May which put a strain on her bowel. Mr X also said that the Health Board was either too slow to recognise or did not recognise complications following Mrs X's bowel surgery. Whilst the Consultant did not examine Mrs X on 1 June, he was content for her to be discharged pending medical review.

The Ombudsman found that whilst Mrs X may not have been placed on the correct category of ward, there was no evidence that she received inadequate care. There was no evidence in the medical records of what food Mrs X ate on 20 May however Mr X's recall was persuasive and the Ombudsman accepted that she ate a substantial meal. Whilst this was not good practice, there was no evidence that this caused any injustice to Mrs X. It was unlikely that the Consultant examined Mrs X on 1 June, which was not good practice. However, Mrs X was not discharged and there was no evidence that this caused any injustice.

The Ombudsman did not uphold Mr X's complaints.

A GP Practice in the Aneurin Bevan University Health Board area – Clinical treatment outside hospital Case Number 201601634 - Report issued in March 2017

Mrs Y complained about the management of her back pain between January and September 2015. She said that the GP had refused to refer her for an MRI scan. Mrs Y said that she was later referred for an MRI scan. As there was a six weeks waiting list she had the MRI scan and later surgery on a compressed nerve in her back privately which she said the Practice should pay. Mrs Y also complained about a comment made by the GP which she found demeaning. Mrs Y said that she had only had telephone consultations and she did not have a home visit.

The Ombudsman investigation concluded that it was appropriate for the GP not to have referred for an X-ray until May. He concluded that the GP's decision not to refer Mrs Y for an MRI scan before August was appropriate and reasonable. The Ombudsman noted that the GP apologised for his comment. The Ombudsman concluded that telephone consultation was appropriate. He was also satisfied it was Mrs Y's decision to have the MRI scan and the surgery carried out on a private basis and therefore she should not be reimbursed. The Ombudsman did not uphold Mrs Y's complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201601040 - Report issued in March 2017

Mr C complained about the treatment his wife, Mrs C, received within the Emergency Department at Ysbyty Glan Clwyd and the necessity of an ambulance journey whilst she was sedated to see a specialist. He complained that his wife's condition was not appropriately assessed and a CT scan was not performed when she was admitted overnight. He also complained that his wife was made to endure an unnecessarily long ambulance journey, whilst sedated following an MRI scan, to see a specialist at a hospital in England.

The Ombudsman found that Mrs C was assessed appropriately and there was no requirement for a CT to be performed based on the symptoms she presented when admitted. The Ombudsman also found that whilst the ambulance journey was excessively long, and it was not ideal that Mrs C was sedated, it was a necessary journey so Mr and Mrs C could see the specialist shortly after her MRI scan. The Ombudsman did not uphold the complaints.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201505085 – Report issued in March 2017

Mrs X complained that Aneurin Bevan University Health Board (“the Health Board”) failed to properly investigate, provide care for or treat her mother, Mrs Y’s, condition while she was a patient at the Royal Gwent Hospital (“the Hospital”). Mrs X considered that Mrs Y had suffered a stroke either before arrival or when a patient at the Hospital. Mrs X was of the view that an X-ray scan of Mrs Y’s head should have been undertaken urgently at the Hospital.

The investigation found that, while acknowledging that there were some shortcomings in the care provided to Mrs Y (particularly in respect of record-keeping), the overall standard of care provided to Mrs Y had been reasonable. The investigation also found that an emergency X-ray investigation of Mrs Y’s head had not been clinically necessary when she attended at the Hospital’s Emergency Department. The complaint was therefore not upheld.

A GP Practice in the area of Cardiff and Vale University Health Board – Clinical treatment outside hospital Case Number 201602123 – Report issued in March 2017

Ms B complained that the Practice did not provide adequate mental health support to her sister Ms C. She said that had an earlier appropriate diagnosis been made, her death might have been prevented. The Investigation found that the actions of the practice were reasonable and there was no direct link between Ms C’s contacts with the Practice and her death more than two years after leaving the Practice.

A GP Practice in the area of Hywel Dda University Health Board – Clinical treatment outside hospital Case Number 201602120 – Report issued in March 2017

Ms B complained that the Practice did not provide adequate mental health support to her sister Ms C. She said that had an earlier appropriate diagnosis been made, her death might have been prevented. The Ombudsman found that the actions of the Practice were reasonable it responded appropriately to the advice of the specialists in secondary services and made referrals where clinically indicated.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201602319 – Report issued in March 2017

Mr A complained that Cwm Taf University Health Board (“the Health Board”) failed to apply the correct process when it detained him under section 2 of the Mental Health Act 1983 (“MHA”) on 14 March 2015.

There was no evidence to suggest that the Health Board’s decision to detain Mr A was unreasonable or inappropriate. The Ombudsman was satisfied that the assessment conducted by the Health Board was appropriate and in line with relevant legislation. He was also satisfied that all relevant considerations were taken into account by the Health Board during its assessment of Mr A. Consequently, the complaint was not upheld and no recommendations were made.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201506296 – Report issued in March 2017

Ms T complained about the care and treatment that her father-in-law, Mr F, received when he was admitted to the University Hospital of Wales on three occasions between September 2014 and January 2015. Ms T complained that, during Mr F's first admission, the family reported to clinicians that he experienced rectal bleeding but this was not recorded and acted upon.

Ms T then complained that, following Mr F's second admission with symptoms of colitis¹, clinicians failed to carry out the surgery he required and prematurely discharged him. This led to Mr F being urgently re-admitted for a third time in order to undergo surgery. Ms T also complained that:

- a) Cardiff and Vale University Health Board ("the Health Board") dismissed her suggestion that Mr F developed sepsis² following extensive dental extractions that he underwent some weeks before his first admission
- b) A Renal Consultant recorded that Mr F had told her that his GP queried whether his rectal bleeding may have been caused by haemorrhoids. However, Mr F did not discuss haemorrhoids with his GP
- c) During Mr F's second admission, the family was told by a Consultant Surgeon that the source of Mr F's colitis was a Hospital Acquired Infection that he contracted during his previous admission. However, these comments were never clarified or recorded in Mr F's medical records
- d) Medical records, supplied on request to the family, were incomplete and documentation was provided to the family during the Health Board's investigation that related to a different patient with the same name as Mr F.

With regard to the complaint that clinicians failed to record the family's reports of Mr F's rectal bleeding on the Renal Unit, the Ombudsman was unable to reach a finding. Whilst the Ombudsman had no reason to doubt the family's account of this matter, the absence of documentary evidence meant that this issue could not be resolved with any degree of certainty. This was similarly true of the complaint that a Consultant (who no longer works for the Health Board) had suggested that the source of Mr F's colitis was a Hospital Acquired Infection.

The Ombudsman did not uphold the complaint that clinicians prematurely discharged Mr F (following his second admission), and did not uphold the complaint that Mr F contracted sepsis as a result of dental extractions. The Ombudsman also determined that the Renal Consultant did not attribute Mr F's rectal bleeding to haemorrhoids, but rather recorded Mr F's account of a consultation with his GP in which this was suggested. The Ombudsman considered that the Renal Consultant's recording this matter did not, in any event, adversely affect Mr F.

Finally, the Ombudsman found no evidence that medical records provided to the family were incomplete but did identify that an email sent to the family during the Health Board's investigation related to a different patient with the same name as Mr F. However, no personal information concerning either patient was disclosed. The Ombudsman, nevertheless, reminded the Health Board of the need for enhanced vigilance in its handling and checking of patients' personal data.

Hywel Dda University Health Board – Appointments/admissions/discharge and transfer procedures Case Number 201600363 - Report issued in March 2017

Mr P complained that Hywel Dda University Health Board's ("the Health Board") scheduling of a hip replacement operation that he underwent at Bronglais Hospital, significantly exceeded the Welsh Government's 36 week referral-to-treatment (RTT)¹ time target for NHS organisations in Wales. Mr P complained that his RTT time amounted in total to 51 weeks and that during this time he was in

constant, acute pain which severely restricted his mobility and prevented him from working.

The Ombudsman determined that there was no clinical justification for an early scheduling of Mr P's hip surgery. He also determined that Mr P's hip replacement was not rendered more complicated for the delay he experienced or that any other harm was done which could have been avoided had the operation been carried out sooner. Despite the Health Board exceeding the RTT target time, and despite the Ombudsman's concern that the Health Board failed to treat Mr P in a timely manner, there was no evidence to suggest that Mr P's wait for surgery could be attributed to mismanagement of his particular case.

Given that the RTT target does not confer on a patient an absolute right to treatment within 36 weeks, and given also that Mr P was no more disadvantaged by the time he spent on the waiting list than the many other patients who, during that year, were equally adversely affected by the breached target, the Ombudsman did not uphold Mr P's complaint.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201604656 – Report issued in January 2017

Ms A complained about the care and treatment provided to her late mother, Mrs B, whilst an inpatient at Glangwili Hospital for the period 11 April 2016 until her death on 3 May 2016 from sepsis.

On receiving the complaint, Hywel Dda University Health Board ("the Health Board") acknowledged its response could have been more comprehensive. It proposed that the complaint be referred back for it to provide an enhanced response to a specific issue and to set out its position under the redress provisions of the Putting Things Right ("PTR") Regulations. Ms A was contacted and agreed with the action the Health Board had agreed to undertake.

On that basis Ms A's complaint was considered to be settled and her complaint was referred back to the Health Board to undertake the agreed action.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number 201605479 - - Report issued in January 2017

Mr P complained about a number of matters relating to Abertawe Bro Morgannwg University Health Board's ("the Health Board") investigation of his complaint about clinical care and failure to diagnose a dislocated collar bone which was still causing him residual problems. In the main, he was unhappy with the outcome and opinions expressed. He also complained that he had not received any three month consultant follow up appointment he was due after his last consultation (which had taken place nine months ago).

On considering the complaint, it was clear to the Ombudsman that a full investigation under the Putting Things Right process had been carried out. This had involved engaging the full Redress provisions in PTR with an independently appointed expert, agreed by solicitors acting for Mr P, reviewing the care. The Ombudsman concluded that it was not possible for Mr P to say that he had not agreed the expert's appointment in those circumstances, and that there was no reasonable basis for the Ombudsman to investigate his dissatisfaction with the opinions given.

The Ombudsman did, however, consider the Health Board could have better managed Mr P's complaint

particularly from a communication point of view. Mr P was originally told the Health Board accepted a breach of duty of care, and would consider financial redress, but this was based on an erroneous conclusion that no X-ray had been taken when Mr P was first admitted and progressed to seek expert opinion on that basis. X-rays had been performed and the expert's opinion was not supportive of a breach of duty. The Ombudsman considered that the Health Board's initial decision had led Mr P to have a legitimate expectation that his complaint had merit and that redress would follow. In all, Mr P waited for a year to then be told of the Health Board's revised position after receiving the expert's opinion. That original misinformation based on an error was an injustice to him. Initial enquiries by the Ombudsman found that there had been a failure to provide Mr P with the three month follow up appointment, which had been overlooked. The Ombudsman felt the following to be a reasonable resolution of those two issues. The Health Board agreed to implement the following recommendations:

- a) To apologise to Mr P (in 14 days) for the failure to provide him with a consultant follow up appointment and to arrange a date for this as soon as practicable
- b) To apologise to Mr P (in 28 days) for the communication failings and resulting complaint handling issues
- c) Within 28 days to also offer him redress of £200 for those failings

Cwm Taf University Health Board - Continuing Care Case Number 201604388 – Report issued in January 2017

Mr A complained that his wife, Mrs Y, had been unsuccessful in obtaining an appointment with the Community Mental Health Team following referrals from her GP and having made requests directly. However, she had been advised by Cwm Taf University Health Board ("the Health Board") that, as a former user of secondary mental health care services, she was entitled to refer herself back for further assessment if her condition deteriorated.

On receipt of the complaint, the Ombudsman contacted the Health Board and it agreed to undertake the following in settlement of the matter:

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

Betsi Cadwaladr University Health Board - Medical records/standards of record-keeping Case Number 201606214 – Report issued in January 2017

Ms X complained about treatment she received in early 2015. Ms X also raised concerns about information noted by a surgeon in her medical records.

The Ombudsman considered that Ms X's complaint about her treatment was out of time for investigation by his office as it was provided nearly two years ago.

However, in relation to information held in Ms X's medical records, it was clear that Betsi Cadwaladr University Health Board ("the Health Board") had agreed to add notations with Ms X's approval at a complaints meeting. Subsequently, the Health Board failed to complete the agreed actions and failed to respond to Ms X's letters to it.

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

- a) Complete the agreed actions of the complaints meeting
- b) Provide a written apology for the delay in completing the agreed actions, and for the lack of correspondence following the meeting.

Welsh Ambulance Services NHS Trust - Clinical treatment in hospital

Case Number 201604812 – Report issued in January 2017

Mr X complained about the treatment and care he received from paramedics after an ambulance attended his property in November 2015. After contacting the Welsh Ambulance Services NHS Trust ("the Trust") it confirmed that it was aware of Mr X's complaint but that it had been dealt with on an informal basis in 2015.

The Ombudsman found that there was opportunity to consider the complaint formally and under the Putting Things Right Regulations. Therefore, the Trust agreed to complete a formal investigation into Mr X's complaint in line with the Putting Things Right Regulations within one month.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201605380 – Report issued in January 2017

Mr X complained that Aneurin Bevan University Health Board ("the Health Board") had not acknowledged or responded to his complaints about a lack of diagnosis for his medical condition. After consideration of the information submitted, the Ombudsman found that although Mr X had attended a meeting with the Health Board, as well as received some correspondence from it, he had not been provided with a comprehensive written response to his 2015 complaint in line with the 'Putting Things Right' Regulations (2011). Therefore, the Health Board agreed to the following within one month of receipt of the decision letter:

- a) Apologise to Mr X for a delay in providing him with a written PTR response
- b) Provide a comprehensive written PTR response addressing his concerns regarding a lack of diagnosis in 2015 and in response to the additional queries raised in his letter of July 2016
- c) Provide any outstanding response from the appropriate clinician in relation to the May 2015 meeting if appropriate.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201605321 – Report issued in January 2017

Mrs B complained about the way Betsi Cadwaladr University Health Board ("the Health Board") has dealt with her complaint in relation to treatment she received in February 2015. Mrs B raised concerns with the Health Board on 2 October 2015 and received a response dated 1 September 2016. In this response the Health Board referred to a Serious Incident Report (SIR) which would follow shortly, however Mrs B had still not received a copy.

The Ombudsman contacted the Health Board to obtain its comments. The Health Board acknowledged that there was a delay in providing Mrs B with the SIR however it was aiming to finalise the report and share it with Mrs B and her advocate early in the month.

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

- a) Provide an apology to Mrs B for the delay in providing the SIR along with an explanation for this
- b) Offer £50 for the delay and time and trouble in raising a complaint to this office
- c) Ensure that the SIR would be shared with the Ombudsman and Mrs B by 25 January 2017.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number 201504813 – Report issued in January 2017

Mr X complained about his late wife Mrs X's treatment at the Singleton Hospital between 3 June 2014 and 6 August. Mr X complained that his wife suffered a severe eye infection, had six unaccompanied falls, lack of physiotherapy care, her oral care led to scurvy, her weight loss was not recognised with no attempt at feeding or Nasogastric ("NG") insertion, the treatment of oedema in her legs, the medical and nursing care, misdiagnosed with Coeliac's disease and a lack of communication.

The Ombudsman upheld the following aspects of the complaint: Mrs X's falls assessment and care plans were not reviewed, he did not accept that Mrs X had scurvy but there were failings in her oral care. Mrs X's weight loss was identified but it was unclear on occasions whether she was fed and she was not referred to a dietician, it was not recorded that Mrs X had aspirated and she was not referred to a Speech and Language Therapist while nutritional supplements increased the risk of aspiration, the frequency and type of leg dressing for Mrs X's oedema were not recorded, the misdiagnosis of Coeliac's disease gave false hope, once weekly ward rounds were insufficient and there had been two weeks without a ward round, and there was poor communication with Mr X.

The Ombudsman found that Mrs X's physiotherapy care was appropriate, but the grounds for further referral were not detailed neither was it explained to Mr Y why it was withdrawn; he partly upheld this aspect of the complaint. The Ombudsman found that Mrs X's eye infection was treated and it was inappropriate for her to have a NG inserted; he did not uphold these aspects of the complaint.

As the Health Board previously implemented changes to its falls policy, oral assessments and care plans the Ombudsman made no further recommendations. The Ombudsman recommended that the Health Board:

- a) audit the standard of calculation for risk scores in nutritional risk assessments
- b) highlight to the Physiotherapy Department the importance of communication with similar patients
- c) arrange for this report to be included as part of the Consultant's next annual appraisal
- d) and write to Mr X with the outcome of these recommendations.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201605381 – Report issued in February 2017

Mrs X complained in October 2014 about Hywel Dda University Health Board's ("the Health Board") care of her mother. After submitting her complaint, Mrs X's mother died. Mrs X raised further concerns about her late mother's care with the Health Board and requested a meeting. Following attempts to organise a meeting and a request for a formal response, Mrs X complained to the Ombudsman about her mother's care and the delay she experienced in receiving a response to her complaint.

The investigation found that although the Health Board had indicated that a response was imminent, it appeared that Mrs X's attempts at an informal meeting to discuss the complaint were to the detriment of this response, which could have been resolved sooner. Therefore, the Ombudsman considered that the matter could be settled. The Health Board agreed to take the following action:

- a) to provide an apology to Mrs X for the management of her complaint and £200 to address the time spent in pursuing the complaint
- b) to provide a formal response to Mrs X complaint
- c) Following the formal response, to hold a meeting with Mrs X to discuss the complaint, should she wish to do so.

Betsi Cadwaladr University Health Board - Continuing Care Case Number 201605725 – Report issued in February 2017

Mr X and Mr X complained that Betsi Cadwaladr University Health Board ("the Health Board") had not followed its own procedures in regard to their request for a review of the decision made concerning their mothers eligibility for NHS Funded Continuing Care ('NHSFCC'). They explained that, at times throughout their correspondence with the Health Board about the review request, some of their letters had not been responded to, they had experienced delays in receiving other responses and they had also been provided with incorrect information about the review.

The Ombudsman concluded that there was evidence of failings in the communication with Mr X and Mr X in regard to the review request.

After contacting the Health Board, the Ombudsman recommended the following early resolution to the complaint, which the Health Board have agreed to undertake:

- a) Provide a written letter of apology to Mr X and Mr X to reflect the delays experienced in relation to their request to the Health Board for a review of their mother's eligibility for NHSFCC
- b) Carry out the formal review of the decisions made in relation to their mother's eligibility for NHSFCC.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case Number 201605586 - Report issued in February 2017

Mrs N complained to Betsi Cadwaladr University Health Board ("the Health Board") about an assessment of her daughter for ASD (Autism Spectrum Disorder). Mrs N was unhappy that the assessment did not result in a diagnosis of ASD. She was also unhappy at a second assessment which she thought had not been

done formally. Mrs N asked for a further assessment from a specific expert in the field of ASD in women in girls.

The Health Board said that the assessment had been carried out correctly and in accordance with national guidance. Nevertheless it agreed to a further assessment. However, it rejected Mrs N's choice of expert and named its own expert to carry out the assessment.

The Ombudsman assessed Mrs N's complaint and agreed that the offer of a third assessment by the Health Board's named expert was reasonable and would resolve her complaint. Therefore the Health Board agreed to write to Mrs N offering a third ASD assessment of her daughter by its named expert.

Betsi Cadwaladr University Health Board – Continuing Care Case Number 201605239 - Report issued in February 2017

Mr X complained (via his representative) that Betsi Cadwaladr Health Board ("the Health Board") rejected to register a claim for retrospective review of continuing care funding for his late mother. The Health Board rejected the claim because it was received outside of publicised date for submission. Whilst recognising that the claim was submitted outside of this period the Health Board were asked to consider the extenuating circumstances which led to the delay which were beyond the control of Mr X.

Having considered the complaint the Ombudsman concluded that the Health Board had not taken the extenuating circumstances highlighted by the complainant in account when rejecting the claim.

The Health Board was therefore asked to:

- a) Accept the case as a late application under extenuating circumstances
- b) Apply the NHS checklist to the claim period
- c) Write to Mr X, via his representative, to apologise for failing to take account of the extenuating circumstances when initially considering the request.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201606127 - Report issued in February 2017

Dr R complained that the Hywel Dda University Health Board ("the Health Board") failed to correctly diagnose her condition and prescribed treatment that exacerbated damage that had already occurred to her eye and vision. Further, that a referral for essential operative treatment was not made and she had to seek care privately in order to restore and save partial sight. Dr R also complained that she raised her concerns in March 2016 but had not received a response.

The Ombudsman found that the delay was unacceptable and amounted to maladministration on the part of the Health Board. The Health Board agreed to undertake the following actions within two months in settlement of the complaint handling:

- a) Apologise and provide a full explanation for the continued delay
- b) Offer financial redress of £250 for Dr R's time and trouble pursuing the complaint

c) Provide a full response within two months from the date of the Ombudsman's decision letter.

Hywel Dda University Health Board - Clinical treatment in hospital Case Number 201606550 - Report issued in February 2017

Ms B complained that Hywel Dda University Health Board ("the Health Board") failed to respond to a complaint she submitted on 22 July 2016. The substance of the complaint related to the care and treatment she received in hospital during the birth of her son. After raising her complaint formally, Ms B attended two meetings in May and October 2016. Following the second meeting Ms B was advised that the Health Board's investigation was complete and a response would be issued. However, she received no minutes or notes of the second meeting or final complaint response.

The Ombudsman considered that the delay was unacceptable and amounted to maladministration on the part of the Health Board. The Health Board agreed to undertake the following actions by 13 March 2017:

- a) apologise and provide an explanation for the significant delays
- b) offer financial redress at the sum of £100; and
- c) provide a full and final response to the substance of the complaint.

Betsi Cadwaladr University Health Board - Medical records/standards of record-keeping Case Number 201606147 - Report issued in February 2017

Mrs C complained that she had attended a pre-arranged appointment with a Consultant at Colwyn Bay Community Hospital. During the consultation it became apparent that her medical notes relating to a previous appointment at Ysbyty Glan Clwyd had not been transferred. This meant that the Consultant was unable to correctly assess her condition which resulted in a non productive consultation.

It was apparent from the information provided to the Ombudsman that she and her husband had travelled approximately 50 miles unnecessarily. Mrs C was also keen that her appointment should be rearranged at the earliest opportunity.

The Ombudsman contacted Betsi Cadwaladr University Health Board and it agreed to deal with her complaint by:

- a) offering a redress payment of £22.50p (50 miles at 45p public transport rate) as redress for the unnecessary journey undertaken by her and her husband.
- b) offering her an appointment to see the appropriate Consultant on a date within 1 month of the date of the decision letter; and
- c) arranging for the Ysbyty Glan Clwyd medical notes relating to her be made available for review by that Consultant on the appointment date provided.

The letter should be sent within 20 working days of the date of the decision letter.

Welsh Ambulance Services NHS Trust – Ambulance services Case Number 201605604 - Report issued in March 2017

Mrs F's local MP complained to the Welsh Ambulance Services NHS Trust ("WAST") in December 2015 about the how a call regarding her husband was categorised incorrectly, thus resulting in a delay in an ambulance attending to him. WAST did not respond until November 2016 apologising for its error and ensuring Mrs F that the call handler had received appropriate training. Mrs F then approached the Ombudsman about the delay in WAST providing its complaint response and querying when the call handler received training considering it took 11 months to respond to her concerns.

The Ombudsman assessed Mrs F's complaint and found that WAST did not have a genuine reason for the delay in its complaint response: in fact, it implied the delay was caused by Mrs F and her MP. WAST did however, confirm that the call handler had received appropriate training within a month of Mrs F's complaint letter. Therefore, in order to resolve this complaint WAST agreed to the following actions proposed by the Ombudsman:

- a) Write a letter of apology to Mrs F for the excessive and unnecessary delay in replying to her complaint; and
- b) Make a payment to Mrs F of £75 for the delay.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201606504 - Report issued in March 2017

Mr X complained that Hywel Dda University Health Board ("the Health Board") failed to return his phone calls and communicate with him regarding the results of a connected Heart Monitor following what he thought was a minor heart attack.

Mr X also complained that the Health Board failed to provide him with a response to his complaint about cardiac investigations, which was submitted in October 2016, and that it has not kept him updated with the progress of its investigation into his concerns.

The Ombudsman contacted the Health Board to discuss Mr X's complaint and make enquiries into the reasons for the delay. The Health Board has agreed to undertake the following (which the Ombudsman will monitor implementation of) in settlement of Mr X's complaint:

- a) to provide Mr X with a full extensive update about what has happened together with an indication about the current position of his complaint
- b) apologise to Mr X for the lack of communication and the delay in providing him with its response, and
- c) to provide Mr X with a full response to his complaint by 19 April 2017.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case Number 201606894 - Report issued in March 2017

Mrs A complained to the Ombudsman about the standard of podiatry treatment provided by Betsi Cadwaladr University Health Board ("the Health Board") at a local clinic. Mrs A said that the cutting back

of her first toe nails had left her in additional pain and discomfort for a number of months. She also said that the appearance of her toe nails had caused her embarrassment. She said that no explanation was provided to confirm why her nails were cut back to this level.

Although the Ombudsman declined to investigate Mrs A's complaint, he recognised that the Health Board had already accepted in its formal complaints response that the standard of treatment provided to Mrs A had fallen below what would have been reasonably expected. Because of this, he contacted the Health Board and it agreed to do the following within one month of the date of this decision:

- a) to provide Mrs A with a full explanation of the reasons why her nails were cut back to this level
- b) to provide Mrs A with a redress payment of £300 in recognition of the additional distress and discomfort that she was caused due to the failure to provide her with a reasonable standard of care during her appointment
- c) to provide the Ombudsman with supporting evidence to demonstrate that Mrs A's experience had been shared with the relevant team as previously indicated in its formal complaints response.

Hywel Dda University Health Board - Other

Case Number 201605958 - Report issued in March 2017

Mrs A complained to the Ombudsman about Hywel Dda University Health Board's ("the Health Board") decisions to refuse her applications for reimbursement of costs for treatment in the European Economic Area. Mrs A underwent right knee replacement surgery at a private hospital in France. The Health Board refused to reimburse her treatment costs because she had the procedure undertaken without its prior approval. Mrs A said that she did apply to the Health Board for prior approval but it took too long to process her application. Consequently the procedure had been undertaken by the time the approval was given. Mrs A went on to make a retrospective application for reimbursement to the Health Board which was also refused because it was not made in good time. Mrs A said that the application was delayed because the Health Board failed to advise her that this was an avenue that she could pursue and of the timescales involved. Mrs A felt that that her applications were refused because of procedural delays caused by the Health Board and that this was unfair.

The Ombudsman found that there was no delay by the Health Board in processing Mrs A's prior approval application. In accordance with the relevant procedures, Mrs A was required to apply and wait for confirmation of prior funding approval before proceeding with her treatment. As she did not, the Health Board had the discretion to turn down her later request for reimbursement of her treatment costs.

However, the Ombudsman questioned why the Health Board had given prior funding approval to Mrs A in the intervening period. As there was no evidence of 'undue delay' by NHS Wales in providing her with the treatment she was seeking, Mrs A did not appear to meet the qualifying criteria for reimbursement of her treatment costs on clinical grounds. The Ombudsman concluded that the prior funding approval gave Mrs A an unrealistic expectation that her claim would be paid.

The Health Board also relied on the fact that Mrs A had previously received reimbursement of her costs for a left knee replacement as evidence that she was fully aware of the funding application and review procedure. The Ombudsman said that this was unfair and that the Health Board's failure to ensure that Mrs A was fully informed of the procedure had contributed to her lack of understanding and inability to progress her applications more quickly. However, this failing did not alter the decision to refuse Mrs A's request for reimbursement.

Although the Ombudsman declined to investigate Mrs A complaint, he recognised that there were some procedural failings. He contacted the Health Board and it agreed to do the following within one month of the date of this decision:

- a) to provide information as standard with its claim acknowledgement letter about the patient's obligations when seeking reimbursement of treatment costs and where to obtain detailed information about the claim and review procedure
- b) to offer Mrs A a redress payment of £100 in recognition of its failure to provide her with timely information about the procedure and any confusion and unnecessary delay that this may have caused
- c) to investigate further the reasons for its initial approval of Mrs A's application and to establish whether there had been any administrative failing
- d) to share the findings of its further investigation with Mrs A and to apologise if any failings were found to have contributed to her expectation that the claim would get paid.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201607452 - Report issued in March 2017

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

The Ombudsman found that the length of time the Health Board had taken to respond to the complaint was excessive and unacceptable. During the Ombudsman's consideration, the Health Board issued its response, and agreed to provide an apology to Mrs N for the delays in complaint handling by 31 March 2017.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201606559 - Report issued in March 2017

Mrs B complained that the Hywel Dda University Health Board ("the Health Board") had not responded to her complaint, which she submitted in June 2016 following an appointment at a Sexual Health Clinic. Although Mrs B was advised that information from the service area had been received, the response was not issued until 21 February 2017.

The Ombudsman found that that the substance of the complaint was not overly complex, and should have been dealt with relatively swiftly by the Health Board. Therefore, the eight month delay was excessive and constituted maladministration on the part of the Health Board.

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

- a) apologise for the significant delay in providing a response, and
- b) offer £100 financial redress for the complainant's time and trouble.

The Health Board agreed to complete these actions by 15 March 2017.

Cardiff and Vale University Health Board - Confidentiality Case Number 201607071 - Report issued in March 2017

A complaint was made on behalf of Ms F about an unauthorised release of information about her health status by Cardiff and Vale University Health Board's ("the Health Board") Community Mental Health Team. Ms F alleged that information was inappropriately shared with her social landlord on two occasions. The Ombudsman considered the way in which the Health Board had responded to the complaints. The Health Board responded to Ms F's complaint and provided details of the relevant policy which enabled them to share information and the rationale for that decision on the first occasion. It also apologised to Ms F for a lack of communication at this time. On review the Ombudsman considered that the Health Board had not adequately investigated or explained the events which led to the second occasion when information was disclosed.

The Health Board therefore agreed to complete the following within one month:

- a) Investigate Ms F's concern and share the outcome with her
- b) Apologise to Ms F for failing to adequately address this issue in the previous investigation of her complaint.

Betsi Cadwaladr University Health Board - Other Case Number 201606762 - Report issued in March 2017

Mrs A complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to respond to her complaint about her father's ("Mr B") care and treatment before he died. Mrs A continued to pursue the complaint after her father's death at the behest of Mr B. Mrs A complained that the Health Board's failure to respond and the significant delay had caused the family to suffer distress and anxiety.

The Ombudsman concluded that the circumstances of the delay in the Health Board providing a complaint response were unreasonable, a delay of some 14 months.

The Health Board acknowledged the delay and agreed to provide evidence to the Ombudsman of the following action in settlement of the complaint:

- a) to apologise to Mrs A for the delay and make a payment of £500 in recognition of the time and trouble taken to pursue the complaint
- b) to expedite its response.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201604940 - Report issued in March 2017

Mrs E complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to properly respond to her complaint about the care her husband received before he died and that the Health Board had refused to meet with her.

The investigation found that the complaint response from the Health Board contained irrelevant information and did not answer all the questions which Mrs E had asked in her complaint. The Health Board had made it very difficult for a meeting to take place, as it said new issues were being raised but this was not the case.

The Health Board agreed to:

- a) apologise to Mrs E
- b) make a payment of £250 in recognition of the time and trouble taken to pursue the complaint, and
- c) arrange a meeting with Mrs E to discuss the concerns she had about Mr E's care and to follow that meeting up with a full complaint response.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201603625 - Report issued in March 2017

Ms A complained about the handling of her complaint by Betsi Cadwaladr University Health Board ("the Health Board") and the considerable delay in a response being provided. She set out the impact the delays had on her.

The Ombudsman concluded that given the circumstances the delay in the Health Board providing a complaint response was unreasonable. As part of the settlement the Health Board agreed to:

- a) apologise to Ms A for the delays
- b) make a payment to her of £250, and
- c) review how it dealt with such cases and to share lessons learnt with its Concerns Team.

Benefits Administration

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Rhondda Cynon Taf County Borough Council – Other Benefits Case Number 201605596 - Report issued in January 2017

Mr X complained that, following a decision by the Ombudsman in April 2016 to refer his complaint back to Rhondda Cynon Taf County Borough Council, ("the Council"), it had failed to respond to him. Mr X also complained that the Council claimed that an Enforcement Agent ("the EA") visited his property, which Mr X said is incorrect.

The Ombudsman, as an independent body, could not reach a definitive finding in regards to the two differing accounts of the visit by the EA.

In regards to the Council's complaint handling, the Council had incorrectly informed the Ombudsman that it had not responded to Mr X under Stage 2 of its complaints procedure in April 2016. Subsequently, the Council informed the Ombudsman that the information it had provided was incorrect. In settlement of this aspect of Mr X's complaint, the Council agreed to complete the following action:

- a) Issue a written apology to Mr X for providing the Ombudsman with incorrect information which led him to understand that a further response would be issued by the Council.

Bridgend County Borough Council – Council tax benefit Case Number 201606513 - Report issued in February 2017

Mrs A complained that Bridgend County Borough Council ("the Council") had, over several years, incorrectly applied her disability benefit when calculating her Council Tax and that she was yet to receive a full refund. The Ombudsman considered that the Council had responded to Mrs A's complaint promptly, it had explained and apologised for the oversight in applying her disability benefit, and had refunded Mrs A £2900. The Council were in the process of determining figures for the disputed period of 2011-2013.

The Council agreed the following actions in settlement of Mrs A's complaint:

- a) Offer £100 to Mrs A in recognition of the time and trouble in making her complaint, and the Council's error in incorrectly applying her benefits
- b) Arrange a meeting with Mrs A to explain the calculations of her Council Tax.

Community facilities, recreation and leisure

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Blaenau Gwent County Borough Council - Cemeteries/Graves/Headstones

Case Number 201604733 - Report issued in January 2017

Mrs X complained that, following the funeral of her late mother, Blaenau Gwent County Borough Council ("the Council") charged her with an additional fee for purchase of the Exclusive Rights of Burial of the plot her mother had been buried in. The Council explained that this was necessary as it does not have any records that this was purchased 51 years ago when her father was interred and that it needed to be purchased now to demonstrate ownership of the grave as well as further authorise any future burial activity at the site.

In consideration of the details of the complaint, as well as Council correspondence regarding the matter, it was apparent that there had been a missed opportunity to remedy the records in 1964 when a baby was interred into the plot. Further to this, it was identified that Mrs X's complaint was not an isolated case and that this could potentially be a systemic problem within the historical cemetery records kept by the Council. Taking this information into account, alongside the fact that authorities have always charged for burial plots, the Ombudsman found that it would not be unreasonable to assume that the plot would have been purchased at the time of the first burial, or at the latest, at the point of the second burial. Whilst the importance of the purchase of the document to update the records now was not questioned by the Ombudsman he found that it would be unfair to expect Mrs X to pay the full cost of the purchase to verify ownership of the plot as the absence of any records should not lead to an automatic assumption that it was not purchased at the time. This would have enabled the Council to benefit from its own maladministration.

In recognition of the above the Ombudsman recommended the following early resolution proposal, which the Council agreed too:

- a) Apologise to Mrs X for the loss of Council records in relation to the matter within one month of receipt of the decision letter.
- b) Provide a redress payment of £100 to Mrs X for her time and trouble in pursuing the complaint with the Council and the Ombudsman within one month of receipt of the decision letter.
- c) Review its records of plot purchases to identify similar incidences within three months of receipt of the decision letter.
- d) Consider comparable actions in response to any other individuals with similar circumstances to Mrs Xs, via comparable reduction in any future purchase fee within three months of receipt of the decision letter.

Complaints Handling

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board - Health Case Number 201605673 – Report issued in January 2017

Mr X complained that Betsi Cadwaladr University Health Board ("the Health Board") had not provided a response to his complaint of September 2016 and that it had incorrectly closed his complaint because he had consulted with a solicitor.

The Health Board agreed to complete the following actions in settlement of Mr X's complaint:

- a) Issue its complaint response by Monday 9 January 2017
- b) Provide a written apology for incorrectly closing the complaint which caused a delay in responding to it
- c) Offer a payment of £50 for the time and trouble in making the complaint to the Ombudsman.

Betsi Cadwaladr University Health Board - Health Case Number 201606228 - Report issued in February 2017

Mr X complained about Betsi Cadwaladr University Health Board's ("the Health Board") lack of communication and the time delay during its investigations into concerns about the care and treatment provided to his son prior to his death. Mr X first raised his concerns with the Health Board in June 2016 and has not yet received a final response.

Upon receiving this complaint, the Ombudsman's office contacted the Health Board to discuss the concerns that have been raised against it. The Health Board advised that it was awaiting information from the GP Practice in order to finalise its investigation. The Ombudsman's office asked the Health Board to carry out the following actions to resolve this complaint:

- a) write to Mr X acknowledging and apologising for the continued delays
- b) provide an explanation of what action it has taken to chase up the responses from the GP practice
- c) commit to expediting the matter, bearing in mind the distressing circumstances and consider giving a deadline.

The Ombudsman was happy that the Health Board agreed to the above proposals.

Newport City Council – Roads and transport Case Number 201606351 - Report issued in March 2017

Mr X complained that when he received Newport City Council's ("the Council") response to his corporate complaint about its delays in responding to his service requests he saw that the letter was dated 16 January 2017 but the envelope was postmarked 17 February 2017.

The Ombudsman contacted the Council to discuss the discrepancy between dates but, at the time of the contacting it, the Council was not able to provide a definitive answer for the error. It agreed to:

- a) carry out an investigation into this, and
- b) write to Mr X with its findings and apologise for the error.

**Betsi Cadwaladr University Health Board - Health
Case Number 201606228 - Report issued in March 2017**

Mr X complained about Betsi Cadwaladr University Health Board's ("the Health Board") lack of communication and the time delay during its investigations into concerns about the care and treatment provided to his son prior to his death. Mr X first raised his concerns with the Health Board in June 2016 and has not yet received a final response.

Upon receiving this complaint, the Ombudsman contacted the Health Board to discuss the concerns that have been raised against it. The Health Board advised that it was awaiting information from the GP Practice in order to finalise its investigation. The Ombudsman asked the Health Board to carry out the following actions to resolve this complaint:

- a) write to Mr X acknowledging and apologising for the continued delays
- b) provide an explanation of what action it has taken to chase up the responses from the GP practice
- c) commit to expediting the matter, bearing in mind the distressing circumstances and consider giving a deadline.

The Ombudsman was happy to report that the Health Board agreed to the above proposals.

**Betsi Cadwaladr University Health Board - Health
Case Number 201607586 - Report issued in March 2017**

An advocate from the North Wales Community Health Council made a complaint on behalf of Mrs B against Betsi Cadwaladr University Health Board ("the Health Board"). The advocate complained that Mrs B has waited eight months for the Health Board's response to her complaint with no indication as to when it will be issued. The advocate also complained that the Health Board had failed to provide updates.

In settlement of the complaint, the Health Board agreed to:

- a) expedite the complaint response
- b) provide an apology for the delay in responding to the complaint and for not providing updates
- c) explain the reason for the delays caused this far
- d) offer a payment of £100 to Mrs B for the time and trouble in making the complaint to the Ombudsman.

Betsi Cadwaladr University Health Board – Health Case Number 201606336 - Report issued in March 2017

Mr D's complaint related to the level of support he received from the Community Mental Health Team, and concern that his Care and Treatment Plan (CTP) did not reflect the goals he wanted to achieve. Mr D complained Betsi Cadwaladr University Health Board ("the Health Board") had failed to investigate his complaint properly and the response was provided six months after the complaint was made.

On being contacted, the Health Board explained that the response was delayed because there were a number of vacancies in the Divisional management structure which made it difficult to appropriately manage concerns at that time. However, the vacancies were now filled, which would improve its ability to manage concerns in a timely manner.

Having considered the evidence, the Ombudsman decided not to investigate the complaint. Although it may have been helpful if the Health Board had explained its position to Mr D at an earlier opportunity, the explanation was plausible and the Health Board expressed its sincere regret and apology for the delay. It was clear that having reviewed Mr D's medical records, and speaking to staff involved in his care, the Health Board had taken reasonable action to investigate his complaint. However, the Ombudsman noted Mr D's concern and the Health Board's earlier comment that the CTP could have been more thorough and contained more detail. The Health Board offered the following by way of resolution, which the Ombudsman felt to be reasonable:

- a) To offer Mr D a meeting to discuss his concerns and consider what else it might be able to do to support him.

Cardiff and Vale University Health Board - Health Case Number 201606910 - Report issued in March 2017

Mrs X complained to Cardiff and Vale University Health Board ("the Health Board") in October 2015 regarding a surgery she underwent. As the Health Board's response was outstanding 18 months after the complaint was made, Mrs X brought her concerns to the Ombudsman.

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

- a) provide Mrs X with a further apology for the delay
- b) provide Mrs X with a payment of £200, and
- c) provide Mrs X with a further explanation for the excessive delay.

Merthyr Tydfil County Borough Council – Adult Social Services Case Number 201606241 – Report issued in March 2017

Mr C complained that Merthyr Tydfil County Borough Council ("the Council") failed to provide an appropriate response to him regarding his complaint that the Council had inappropriately shared information with a third party. Mr C explained that an initial investigation dealt with a complaint against one member of staff, but that he later clarified and made a new complaint against another member of staff. The Council refused to progress the complaint to Stage 2 and concluded that the matter had already been

fully investigated and responded to.

The Ombudsman found that when the Council responded to the second complaint, it failed to fully acknowledge or address the new information provided by Mr C. The Council relied upon a previous letter about the matter that predated his clarification of the details of his complaint, and failed to provide clear and relevant reasoning for its decision not to investigate the complaint further

The Council agreed to undertake the following actions:

- a) To communicate clearly its reasoning behind the decision not to investigate the complaint further, taking into consideration the new information provided by the complainant.
- b) To provide an apology and response to Mr C by 31 March 2017.

Education

UPHELD

Student Loans Company - Other

Case Number 201502629 - Report issued in January 2017

Mr E complained about the manner in which the Student Loans Company ("SLC") handled his application for consideration as an independent student in 2014. In particular, he was concerned that he was given incorrect advice about the income evidence that he needed to provide in order to prove independent status.

The Ombudsman found that between 4 and 22 August, SLC staff gave factually incorrect advice to Mr E. The tone of an email sent to Mr E by SLC staff on 11 August was also unprofessional, inappropriate and overly familiar. The Ombudsman upheld the complaint.

The Ombudsman concluded that this did not affect Mr E's entitlement to student support payments based on the entitlement criteria. However, he noted that there was a lack of clarity in some of the communication between SLC and Mr E, and Mr E had to spend additional time pursuing and escalating matters with SLC.

The Ombudsman recommended that SLC:

- a) provide an apology to Mr E
- b) pay £250 financial redress for the shortcomings identified, and
- c) consider some of the issues raised in this complaint about the need for clear advice and recording of emails.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Conwy County Borough Council - Other

Case Number 201605441 – Report issued in January 2017

Mr A complained about the way in which his complaints about a decision taken by the Conwy County Borough Council ("the Council") had been investigated.

Due to the circumstances of the complaint the Council arranged for an Independent Investigation of Mr A's concerns. In his complaint to the Ombudsman Mr A said that the report had been merged with other complaints and then redacted to protect identities making it incomprehensible. He said also that the report failed to address all of his complaints or produce evidence to support the conclusions reached.

The Ombudsman agreed with the concerns raised by Mr A. The Council was therefore asked to arrange for a fresh independent investigation of the concerns raised by Mr A within three months. The Council agreed to this request.

Environment and Environmental Health

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council - Pest control/Dog nuisance/Fouling

Case Number 201606034 - Report issued in February 2017

Mr X complained on behalf of Mr Y that Cardiff Council ("the Council") had not appropriately handled a bee hive contamination at Mr Y's property.

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

- a) Complete outstanding repair works to Mr Y's property
- b) To ensure there is no further contamination from the bee hive, the Council's Pest Control Manager will attend Mr Y's property.

The above actions were agreed to be completed following Mr X or Mr Y contacting the Council to arrange suitable appointments.

Wrexham County Borough Council – Pollution and pollution control measures

Case Number 201606157 - Report issued in March 2017

Mr W complained about the length of time Wrexham County Borough Council ("the Council"), had taken to carry out a contaminated land assessment of the land his property was built upon. The assessment was required by Part 2A of the Environmental Protection Act 1990, which came into force in 2001, and has Statutory Guidance which was recently revised in 2012.

In September 2012, Mr W was first informed an assessment was required. His complaint concerned the time the assessment had taken and his view that there had been a lack of infrastructure to support the required assessments, as they were still ongoing in 2016. Mr W also wanted to know why information about potential land contamination was not disclosed at the time he was purchasing his property and searches carried out.

On considering the documents, the Ombudsman concluded that his powers did not extend to questioning the approach and decisions taken by the Council, and that the time taken to complete the assessments were reasonable in the context of the work that was necessary. Neither could the Ombudsman deal with matters relating to Mr W's property purchase given the length of time that had elapsed since this took place. However, Mr W could make enquiries of his solicitor.

The Ombudsman did conclude that the Council might have communicated better with Mr W and in the circumstances it could have provided more frequent updates about the progress of the assessment. This would have been appropriate particularly in light of the timescale set out in the initial information sent to Mr W, which might be construed as misleading. The Ombudsman proposed a resolution of that issue. The Council agreed to undertake the following in settlement of the complaint:

- a) to review the information provided in Question 3 of the Council's 'Part 2A Frequently Asked Questions for Residents' information booklet and amend the section dealing with timescales. This action to be completed within two months and a copy provided to the Ombudsman.

b) to remind the Contaminated Land Officers of the importance of good record keeping of discussions and meetings with individuals, in particular the dates and persons present, even if they are deemed to be of a more informal nature. This action is to be completed within one month and a copy of the communication provided to the Ombudsman.

c) to provide the complainant with written updates about progress every 6 weeks, or sooner, if the Council becomes aware of any information which could alter timescales or additional work required. These updates to begin within one month and continue until all assessment works have been concluded. Thereafter, the final assessment report is to be sent to the complainant. A copy of the first and final update to be provided to the Ombudsman.

Housing

UPHELD

Rhondda Housing Association Ltd – Repairs & maintenance Case Number 201503578 - Report issued in January 2017

Mr and Mrs A complained about the way in which Rhondda Housing Association Ltd ("the Association") responded to their repair requests. They said that it had taken too long to complete their repairs. They also reported that it had failed to notify them, in advance, of the repair-related visits made by its contractors. They said that it had not investigated their complaints, about these issues, adequately. They also indicated that they were dissatisfied with its management of appointments for a boiler service.

The Ombudsman upheld the repair-related and complaint handling parts of Mr and Mrs A's complaint. He recommended that the Association should apologise to Mr and Mrs A. He asked it to confirm that they are entitled to complain to the Association and that it will deal with their complaints. He recommended that it should:

- a) pay Mr and Mrs A £300 in recognition of the inconvenience caused by the failings identified
- b) complete another risk assessment in respect of them
- c) introduce a mechanism, which enables it to establish that a tenant consents to an unannounced repair-related visit
- d) give him evidence, which shows that it has been monitoring the compliance of its contractors with its announced visit requirement.

The Association agreed to implement these recommendations.

Aelwyd Housing Association - Tenancy rights and conditions/abandonment and evictions Case Number 201602040 - Report issued in January 2017

Ms X complained about Aelwyd Housing Association's ("the Housing Association") handling of her allegation that a tenant in the sheltered housing complex ("the complex") at which she was a resident, Mr Y, had been allowing access to Ms Z. Ms Z had been harassing her. The investigation focused upon events that occurred and action taken by the Housing Association following the issue of a Notice of Seeking Possession ("NOSP") to Mr Y on 3 August 2015.

The Ombudsman found that the Housing Association was entitled to reach the decision to issue a NOSP to Mr Y. However, he was critical that it did not give consideration at that time to any other means of addressing Ms Z's behaviour, including a civil injunction. The Ombudsman was also critical of the way in which the later decision not to issue a civil injunction was reached, particularly given that all other action taken was ineffective. The Ombudsman upheld the complaint.

The Ombudsman was satisfied that Ms X suffered the injustice of having to make repeated complaints which were not fully addressed, as a result of which she decided to move from the complex. He recommended that the Housing Association:

- a) apologise to Ms X
- b) make Ms X a payment of £500
- c) consider taking further action if the anti social behaviour complained about was continuing
- d) review its actions in the matter and provided every relevant member of staff and his office with a copy of that consideration.

The Housing Association agreed to implement the recommendations.

NOT UPHELD

Wales and West Housing Association - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number 201603698 – Report issued in February 2017

Mrs X lived in a retirement property managed by Wales and West Housing Association (“the Housing Association”). Mrs X was registered deaf and wore a hearing aid during the day, which she removed at night leaving her profoundly deaf. Mrs X complained that despite several requests, the Housing Association had failed to implement appropriate measures, which took into account her age, health and disability, to ensure that she was alerted in the event of a fire occurring in one of the building’s communal areas at night.

The Ombudsman found that the Housing Association had made reasonable adjustments to alert Mrs X to a fire in her flat. With respect to the communal areas, the investigation found that the Housing Association took Mrs X’s concerns seriously and sought advice from the Fire Service and was assured that the current fire safety measures were appropriate. Finally, the investigation found that the Housing Association had taken into account Mrs X’s disability and its obligations under the Equality Act and made a decision that it was entitled to make, to ensure both the safety of Mrs X and the other residents of the building. The complaint was not upheld.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Wrexham County Borough Council - Repairs and maintenance

Case Number 201605454 – Report issued in January 2017

Mrs C complained that Wrexham County Borough Council (“the Council”) had failed adequately carry out works to the roof of her porch and house as had been agreed under its Group Repair Scheme.

The complainant, in her submission to the Ombudsman, provided a photograph that appeared to show damage to one of the tiles on the porch roof.

The Council was contacted and agreed to instruct its contractor to:

- a) replace the identified chipped slate on the porch roof, and

- b) check the adequacy of the roof coverings to the main house.

It would undertake this within 20 working days of the date of this letter. The Ombudsman believed that this was a reasonable action to resolve the complaint.

United Welsh Housing Association - Neighbour disputes and anti-social behaviour

Case Number 201604503 – Report issued in January 2017

Ms K complained to the Ombudsman about the way United Welsh Housing Association (the Housing Association) had handled allegations she had made of anti-social behaviour (ASB) against her neighbours and allegations made against her and her family. The Housing Association had erroneously put Ms K on an Acceptable Behaviour Contract before withdrawing it. It also did not follow up a complaint made by Ms K about her neighbour.

The Ombudsman assessed Ms K's complaint, and whilst he concluded that the Housing Association had issued an appropriate apology for the elements of Ms K's concerns it had upheld, he recommended that it took further action to resolve the outstanding concerns. The Housing Association agreed to arrange a meeting between Ms K and officers of the Housing Association to discuss ASB issues and agree a way of moving forward.

Bron Afon Community Housing Ltd - Estate management and environment/common areas/hedges and fences etc

Case Number 201606207 - Report issued in February 2017

Mr G complained that Bron Afon Community Housing Ltd ("the Housing Association") had failed to protect public amenity land and that it should erect notices to try to prevent people using common land for parking. The Housing Association agreed to look into the matter but appeared to take no further action.

After six weeks Mr G indicated he wished to raise a formal complaint about the issue, but still did not receive a response.

The Ombudsman found that the, overall, four month delay in response was unacceptable and that the Housing Association had further failed to escalate the complaint appropriately or provide Mr G with information on its complaints procedure.

The Housing association agreed to undertake the following actions within 20 working days of the Ombudsman's decision:

- a) Apologise for the handling of Mr G's concerns and the failure to recognise and escalate his complaint appropriately
- b) Ascertain why this was not done and take appropriate action to minimise a recurrence
- c) Offer £50 financial redress for Mr G's time and trouble in pursuing the complaint
- d) Provide a full and final response to the substance of the complaint.

Hafod Housing Association – Repairs and maintenance

Case Number 201606784 - Report issued in March 2017

Mrs M complained that Hafod Housing Association (“the Housing Association”) had failed to complete repairs to the roof of her property. Mrs M initially reported the problem in October 2015 but only limited and insufficient repairs had been conducted and the roof was leaking in several places, leading to water damage to the communal areas of the property and flooding of the electrics.

The Ombudsman found that the Housing Association failed to ensure the required works were completed, and failed to deal appropriately with Mrs M’s further reports that the problem was not resolved. Despite investigating and upholding a formal complaint in December 2016, the Housing Association again failed to follow-up on the works and carry out the actions it had agreed to resolve the issue.

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

- a) Review how works satisfaction surveys are recorded and actioned
- b) Review this complaint with all staff involved to identify where service failures occurred and to learn from those mistakes
- c) Provide Mrs M with a written apology and reassurance that lessons have been learned to prevent a reoccurrence of the problems in repairing, and monitoring, the initial leak and subsequent problems
- d) Offer financial redress at the sum of £500
- e) Having organised for the roof repair, undertake to complete all other agreed works, including replacing damaged furnishings, assessing and treating damp and water damage, resealing the windows and reconnecting the electrics, and
- f) Complete all agreed recommendations within eight weeks of date the Ombudsman’s decision.

Planning and Building Control

UPHELD

Powys County Council – Other planning matters

Case Number 201505697 - Report issued in February 2017

Mr and Mrs X complained that a Planning Officer ("the Officer") granted planning permission by delegated authority for a new development of apartments which abounded their property and that the application should have been considered by Powys County Council's ("the Council") Planning Committee because of the development's size, mass and impact on light as material considerations. They said that the drawings did not show the development from neighbouring properties perspective and showed that two storey blocks would face their boundary but they are faced by a three storey block with the two storey block along the length of their property, which has led to a loss of privacy and being overshadowed. They complained that the Planning Officer had not had not applied the material consideration of the 25 degree rule (height of new development generally be set below 25 degrees from the nearest habitable window) to show the development met policy.

The Ombudsman did not uphold the following aspects of Mr and Mrs X's complaint: the application fell within the terms of a delegated authority, the Council's Planning Protocol had been followed and the development was not a material departure from the Council's Development plan, the three storey building was behind Mr and Mrs X's garage and that the Officer was aware of this, the drawings prepared were comprehensive with sufficient detail for the appearance and impact on neighbouring properties to be assessed.

The Ombudsman partly upheld that the Officer should have included the 25 degree rule, but it is not a mandatory requirement. The Ombudsman made no recommendation in view of the Council's directions that this consideration should be discussed with a senior officer for proposed future developments.

Planning Inspectorate – Other planning matters

Case Number 201601085 - Report issued in March 2017

Ms A complained that her claim for costs against her Local Planning Authority ("the LPA") was not considered during her appeal to the Planning Inspectorate ("the Inspectorate") against the LPA's refusal of planning permission. Ms A complained that the Inspectorate failed to identify that a claim for costs could not be considered via the written representations appeal process she was following. Ms A said that, as a result, her claim for £1700 of professional adviser's fees, as well as approximately £30,000 of costs associated with the original planning application, was not heard.

The Ombudsman found that the Inspectorate's maladministration of Ms A's appeal application denied her the opportunity to pursue a claim for costs against the LPA. The Ombudsman, having taken appropriate professional advice, concluded it was more likely than not that Ms A would have been successful in her costs appeal. The Ombudsman therefore recommended that the Inspectorate should:

- a) reimburse Ms A for the £1700 professional adviser fees, together with a further £250 in recognition of the time and trouble to which she had been put in pursuing her complaint.

EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

Isle of Anglesey County Council – Unauthorised development

Case Number 201606563 - Report issued in March 2017

Mr and Mrs A complained about the handling of their complaint by the Isle of Anglesey County Council ("the Council"). They had complained to the Planning and Highways Departments about their neighbour erecting a fence which directly adjoined their driveway. They were concerned about an increased likelihood of an accident occurring, due to the restricted view at their driveway entrance. Further concerns were also raised, but these did not fall within the Ombudsman's jurisdiction.

Mr and Mrs A suggested there had been a breach of planning control, as the development fell outside permitted development rights. The Council had advised the developer to make a retrospective planning application, but one had not been submitted. Mr and Mrs A felt the Council should have taken enforcement action. Furthermore, Mrs A had sent two letters, written in the Welsh language, to the Highways Department of the Council and these had not received any acknowledgement or response. Mr A had been in correspondence with the Council, but his complaint was not referred to the Corporate Complaints procedure.

The Ombudsman concluded that he could not deal with the main substance of Mr and Mrs A's grievance as the decision not to take enforcement action was a matter of officer professional judgement which he could not question. Nevertheless, he considered there to be some complaint handling failings which might be resolved by actions on the part of the Council. It agreed, within one month of the date of this decision to:

- a) apologise to Mr A for the way in which the Council handled his complaint
- b) apologise to Mrs A for failing to acknowledge or respond to the two letters she sent to the Council. Furthermore, the apology would be provided in the Welsh language
- c) make a payment of £25 to Mrs A in recognition of the time and trouble she spent in her correspondence that went unanswered.

Ceredigion County Council – Handling of planning application (other)

Case Number 201606913 - Report issued in March 2017

Mrs A complained that Ceredigion County Council ("the Council") did not provide clear information about the necessary fees when submitting a revised planning application. As a result Mrs A experienced difficulties and delays during the application process.

The Ombudsman concluded that on this occasion the Council's action in failing to provide Mrs A with clear information amounted to an injustice.

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

- a) In respect of the difficulties and delays experienced with a planning application to pay Mrs A the amount of £250 as a goodwill gesture.

Ceredigion County Council – Handling of planning application (failure to notify those involved)

Case Number 201606869 - Report issued in March 2017

Mr A complained that Ceredigion County Council (“the Council”) had delayed in dealing with his complaints about a number of matters surrounding a planning development near his home. These included that he was not consulted as a neighbouring property owner, and so unable to object, and that he had concerns about how the development was appraised before permission to develop was granted. He also complained about other matters that were not within the Ombudsman’s jurisdiction.

The Ombudsman cannot question the merits of a planning decision. He is only able to determine if the correct process has been followed. Having made initial enquiries of the Council, the Ombudsman was satisfied from the evidence seen that the Council had followed due process in terms of consultation and that no investigation was warranted. Whilst a letter purporting to be for Mr A had been misaddressed, and so not reached him, the Council had consulted in other ways (over and above the statutory requirements), so that was not an injustice to him. The development was also well publicised locally, including by the holding of a public meeting. Documents seen by the Ombudsman demonstrated that a careful appraisal had been undertaken, and that officers had initially recommended refusing the application for specific reasons. However, elected members sitting on the planning committee had been content to approve it, subject to strict planning conditions being imposed, and after careful consideration of the application which included undertaking a site visit.

There had been a delay in responding to Mr A’s subsequent complaint and further questions, which was acknowledged by the Council. It agreed to the Ombudsman’s proposal to resolve that aspect of the complaint by undertaking the following actions within one month, providing evidence to him that it had done so:

- a) Apologise in writing to Mr A for the delay in responding to his complaint and additional questions
- b) Offer him redress of £50 for that failing and his time and trouble in having to pursue that issue with the Ombudsman.

Self-funding care provider

UPHELD

Hallmark Care Homes Ltd – Care homes

Case Number 201505285 – Report issued in January 2017

Mrs Y was a resident of a Care Home. Mrs X complained about a Nurse's decision to commence Cardio-Pulmonary Resuscitation ("CPR") despite Mrs Y's Do Not Attempt CPR ("DNACPR") status. She also complained about the impact on Mrs Y's care of the Nurse's poor language skills when she spoke to an emergency call handler. Additionally, Mrs X complained about the way the Care Home dealt with her complaint and the factual inaccuracies in its complaint response.

The investigation found that the Nurse, who was at the scene and responsible for the immediate care of Mrs Y, was the responsible clinician for the purposes of the relevant guidance. The events of that day concerned an emergency situation and not the circumstances envisaged when Mrs Y's DNACPR decision was made by Mrs X. The Nurse's decision to commence CPR was based on her clinical assessment that Mrs Y was choking and was a justified departure from Mrs Y's DNACPR decision in accordance with the relevant guidance. The decision to commence CPR was reasonable in the circumstances. The Nurse's communication difficulties ultimately had no impact on Mrs Y's care as the correct decision was made. This issue was not upheld.

The complaints handling issue was upheld by the Ombudsman and he recommended that Hallmark Care Homes Ltd apologise to Mrs X for the identified shortcoming, which the Care Provider agreed to implement.

Hafod House Residential Care Home – Care homes

Case Number 201600121 - Report issued in March 2017

Mrs X complained about the care and treatment her mother in law, Mrs Y, received from Hafod House Residential Care Home ("the Care Home"). Mrs X said that there had been a failure to ensure Mrs Y's attendance at her medical appointments. Mrs X also complained that there had been a failure to monitor Mrs Y's skin viability. Finally, Mrs X complained about poor record keeping and said that there had been a failure to adequately respond to her complaints.

The Ombudsman found that whilst alternative medical appointments had been made, the Care Home failed to inform Mrs Y's family of the changes or give them an opportunity to make alternative arrangements. The investigation also found that the Care Home had failed to appropriately assess and monitor Mrs Y which placed her at risk.

Finally, the Ombudsman found that the Care Home's poor record keeping resulted in Mrs Y being placed at a financial detriment, because it had not kept an appropriate inventory of her items and she had to replace those items at her own cost. Additionally, he found that the Care Home had failed to respond to Mrs X's complaint in accordance with its own procedure.

The Ombudsman recommended that the Care Home:

- a) apologise

- b) pay Mrs X and Mrs Y £250 in recognition of the failings identified
- c) remind officers of the need for regular communication with family members and provide refresher training on record keeping and assessment, and
- d) produce a policy on managing residents in the event that the lift is out of order and a policy on the cancellation of resident's medical appointments.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Wrexham County Borough Council – Domiciliary care Case Number 201605823 - Report issued in February 2017

Ms E complained to the Council about Council funded domiciliary care provided to her late mother by an independent care organisation. She was particularly unhappy about the number of carers her mother had in a 12 month period and an overall failure to provide continuity of care.

Ms E received a complaint response from the independent care organisation, which she remained unhappy with, but did not receive one from the Council. The Council eventually responded; however, Ms E was not given the opportunity for an independent Stage 2 investigation in line with its published complaints procedure.

The Ombudsman assessed Ms E's complaint and agreed with the Council for it to take the following action to resolve her complaint:

- a) Carry out an independent Stage 2 investigation in line with its published complaints procedure.

Cardiff Council – Domiciliary care Case Number 201605593 - Report issued in March 2017

Mrs G complained about the way in which her concerns were investigated by a care provider whose services were commissioned by Cardiff Council ("the Council"). Specifically she complained that there was little communication with her during the investigation and the outcome of it and associated disciplinary proceedings had not been shared.

Whilst recognising that matters relating to the complaint handling by the care provider were not within the Ombudsman's jurisdiction, as the commissioner of the care services, the Council's actions were considered. Enquiries identified that the investigation of the concerns was instigated at the Council's request following an Adult Protection enquiry and the outcome shared with them. The Ombudsman concluded that it would have been reasonable for the Council to have shared this outcome with Mrs G. The Council acknowledged this and accepted it as a learning point. In addition the Council agreed to:

- a) write to Mrs G explaining actions taken and the outcome of the investigation completed
- b) apologise that the outcome of the investigation was not shared earlier, and
- c) use its best endeavours to arrange for the care provider to write to Mrs G detailing the outcome of the disciplinary proceedings and to provide apologies for poor communication and complaint handling.

Social services - Adult

UPHELD

Gwynedd Council – Services for vulnerable adults

Case Number 201503803 – Report issued in January 2017

Mrs X complained, on behalf of her son, Mr X, about how Gwynedd Council (“the Council”) had assessed his needs in March 2015. Mr X, an adult with mild learning disabilities and limited mobility, had been receiving nine hours of one to one support a week but this was withdrawn completely. Mrs X was also aggrieved about the inadequacy of alternative services offered by the Council following the withdrawal of one-to-one support. Mrs X was concerned that withdrawing the one-to-one support had a significant detrimental impact on Mr X.

The investigation found a number of shortcomings in the way the Council handled the process. Firstly, the Council decided to withdraw Mr X’s services without first reassessing his needs, as it was required to do. Secondly, the Council failed to meaningfully consult with Mr X about alternative support to meet his assessed needs. Thirdly, the Council appeared to have followed a service-led rather than a person-centred response to Mr X’s assessed needs and the changing of his support package. These shortcomings amounted to maladministration and caused Mr X significantly more distress than he would otherwise have experienced had the process been properly undertaken. The complaint was therefore upheld.

The Ombudsman recommended that the Council should:

- a) apologise to Mr X and Mrs X
- b) offer Mr X £500 as redress
- c) offer to reassess Mr X and arrange any necessary training in light of the criticisms made in the report.

The Council agreed to implement the recommendations.

A Care Home in the area of Cardiff and Vale Health Board - Services for vulnerable adults

Case Number 201503370 – Report issued in February 2017

Mr B complained about the standard of care provided to his adult daughter, Ms B, at a care home run by an independent national care provider. Ms B died in January 2015 following an incident at the care home when she choked on food. A Protection Of Vulnerable Adults (POVA) investigation took place which found that there were management failings at the Care Home. Specific care documentation [a SALT assessment] had not been shared with care staff. As a result of the POVA process, a number of recommendations were made to improve the systems at the Care Home.

The Ombudsman upheld the complaint. Ms B should have been supervised whilst she was eating, given her assessed needs. The recommendations made as a result of the POVA process were appropriate to address

the issues highlighted and no further recommendations were needed in relation to the Care Home's systems. However the Ombudsman recommended that the Care Home:

- a) apologise to Mr B, and
- b) offer to meet with him to provide an explanation of the action it had taken.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Caerphilly County Borough Council – services for older people Case Number 201604904 – Report issued in January 2017

Mrs X complained that Caerphilly County Borough Council ("the Council") had failed to provide her with a Stage 2 complaint response letter after agreeing to as part of an early resolution settlement with this office in July 2016.

On receipt of the complaint, the Ombudsman contacted the Council and, although it confirmed that a response had actually been provided, it accepted that there had been failures in respect of its communication with Mrs X about the correspondence she had received and in providing an explanation to her of its complaint procedures.

The Council therefore agreed to resolve the complaint on the following basis:

- a) Send a letter of apology to Mrs X for the confusion caused in relation to the handling of her complaints by the Council
- b) Provide a redress payment of £75 to Mrs X to reflect the distress caused to her throughout the handling of her complaint and to represent the time and trouble taken in approaching this office

Newport City Council - Services for vulnerable adults Case Number 201605612 – Report issued for January 2017

Mrs X complained that Newport City Council ("the Council") had failed to correctly assess the financial circumstances of her son in relation to the charges he is required to pay for non-residential services. Further to this, she complained about the outcome of a Protection of Vulnerable Adults ('POVA') meeting in relation to the matter that removed her appointeeship from her son and resulted, in her view, in an unwanted and inappropriate advocate for him.

Whilst no failings were found in relation to the Councils actions regarding the financial assessments and reviews completed, the Ombudsman found that there was opportunity to provide a comprehensive and full response to the complainant in respect of the POVA investigation and its results. Therefore, the Council agreed to the following within one month of receipt of the decision letter:

- a) Provide a complaint response to Mrs X explaining how the POVA investigation was carried out, how the decisions were arrived at and consider how the Council has communicated with Mrs X about this.

Carmarthenshire County Council – Services for older people

Case Number 201604627 - Report issued in March 2017

Mr X complained that Carmarthenshire County Council's ("the Council") Social Services Department had failed to provide adequate support with the care of his elderly father who has dementia. Mr X also complained that the Council's independent investigation into his concerns had been "superficial" and the investigation report had failed to address his concerns.

The Council agreed to resolve the matter and undertake the following action:

a) To conduct a fresh independent investigation into Mr X's complaints ensuring that there is evidence of robust consideration of the complaints. It was also agreed that prior to starting the investigation the Independent Investigator would fully explain the process to Mr X and ensure that he fully understands his involvement within the process.

Social services - Children

UPHELD

Ceredigion County Council - Other

Case Number 201503482 - Report issued in January 2017

Mr and Mrs A complained about Ceredigion County Council's ("the Council") handling of their complaint. In relation to their Stage 1 complaint they questioned the appropriateness of the Service Manager undertaking the investigation when their complaint was about him and his team. In relation to the Stage 2 investigation, Mr and Mrs A said that their complaint had not been investigated properly and referred for example to the fact that the focus and conclusions appeared inaccurate.

The Ombudsman's investigation concluded that in relation to Mr and Mrs A's Stage 1 complaint wider considerations (such as the need to give the appearance of openness and transparency and to help avoid the process being tainted by the suggestion/perception of bias), would have justified the then Service Manager not being involved in the process. To that limited extent only this part of Mr and Mrs A's complaint was upheld.

In relation to Mr and Mrs A's Stage 2 complaint the Ombudsman concluded that in the context of the Stage 2 report that communication could have been better. To that extent this part of Mr and Mrs A's complaint was upheld.

The Council had previously offered to facilitate a mediation meeting with Mr and Mrs A. This formed part of the Ombudsman's recommendations. The Council was also asked to:

- a) apologise for the failings identified, and
- b) to make a payment of £250 in recognition of the inconvenience caused to Mr and Mrs A.

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

Case Number 201505700 – Report issued in February 2017

Ms G complained about Monmouthshire County Council's Children's Services Department's ("the Council") removal of her son from her care, specifically that it failed to make reasonable enquiries in reaching its decision about whether any action should be taken to safeguard her son. Ms G said that the Council's decision to remove her son was made inappropriately and without reasonable consideration of his welfare. Ms G also complained that the Council failed to follow good practice in securing her voluntary agreement to the removal of her son.

The investigation found that although there were reasonable grounds for concern about Ms G's child and the decision to remove Ms G's child was appropriate, its implementation of removing her child was poor. The investigation also found that there were failings in the Council's application and understanding of the voluntary agreement in securing Ms G's agreement. There were also failings in the Council's record keeping in relation to its decisions. The Ombudsman upheld the complaint.

The Ombudsman recommended that the Council:

- a) apologise to Ms G for the failings identified in his report
- b) provide thorough training and supervision to its social workers and managers in the application of voluntary agreements
- c) remind social workers of the importance of adequately documenting decisions and discussions in accordance with professional standards, and
- d) ask that managers to set up a schedule of audits of social work recordings to ensure that standards are met.

The Council agreed to implement the recommendations.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

City and County of Swansea - Children in care/taken into care/'at risk' register/child abuse/custody of children

Case Number 201604709 – Report issued in January 2017

Mr C complained to the Ombudsman about action taken by the City and County of Swansea council ("the Council") to safeguard his stepson and the effect on his family.

Although the Council was not able to take a complaint from Mr C about services provided for his stepson, the Ombudsman found that its written response did not fully address Mr C's own concerns and suffering as a result of the Council's actions.

The Council agreed to review Mr C's complaint and to provide him with a more full response under stage two of its Corporate Complaints Procedure.

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

Case Number 201605978 / 201605928 - Report issued in March 2017

Mr X complained on behalf of himself, his partner (Ms Y) and his partner's mother (Mrs Z) about how they had been depicted in a report prepared by Social Services that was submitted to Court during care proceedings in relation to his son. He claimed that the misrepresentation in the report resulted in an Order being made by the Court which placed restrictions on their access to Mr X's son. Mr X also complained about Flintshire County Council's ("the Council") delay in the handling of his complaint, data protection concerns and the advice that a Council Social Worker provided to Ms X and Mrs Y in a meeting after the Court hearing.

The Ombudsman found that the majority of Mr X's complaint was outside of his jurisdiction (given he cannot deal with matters decided at a Court hearing). He did not identify any failings in relation to the timeliness of the handling of his complaint. However, he concluded that there was evidence of failings in

the thoroughness of the complaint response provided to Mr X and that the Council had not addressed Ms Y and Mrs Z's concerns about the advice provided to them by the Social Worker after the Court hearing. After contacting the Council, the Ombudsman recommended the following early resolution to the complaint, which the Council agreed to undertake by 30 March 2017:

- a) Provide a response in writing to Ms Y addressing her questions about the information provided to her by the Social Worker at the meeting after the Court hearing, and
- b) Provide a further response in writing to Mrs Z addressing her questions about the information provided to her by Social Worker at the meeting after the Court hearing

Various - other

UPHELD

Merthyr Tydfil County Borough Council – Other miscellaneous Case Number 201503736 – Report issued in February 2017

Mr X complained that Merthyr Tydfil County Borough Council (“the Council”) failed to properly advertise, and make appropriate land ownership enquiries when it decided to sell land it owned (“Plot A”) adjacent to Mr X’s property. Mr X owned land by Plot A, which he let to his former tenants. The Council sold Plot A to Mr X’s former tenants.

The Ombudsman considered whether there was any administrative fault in the Council’s decision making process and the way Plot A was disposed of.

The investigation concluded that there was no legal requirement for the Council to advertise its land for sale as it was not “open space land”; this complaint was not upheld. The Council’s process allowed it to dispose of land deemed surplus to requirements subject to certain enquiries. The investigation concluded that the Council failed to make necessary ownership enquiries of Mr X in accordance with its process. Accordingly, this complaint was upheld.

The Ombudsman recommended that the Council:

- a) apologise to Mr X for the shortcomings identified
- b) remind/train its staff on its process, and
- c) obtain an independent external valuation report, to determine the difference in value to Mr X’s land, had the Council sold Plot A to him, in accordance with its process.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Other miscellaneous Case Number 201604831 – Report issued in January 2017

Mr S complained that Cardiff Council (“the Council”) had failed to provide him with prior notice that the compound where he rented a garage from it was to be used by its contractors carrying out maintenance work in the area. This caused him problems with access to his garage because of vehicles parking in front of it. He also raised concerns about Health & Safety issues due to construction vehicles driving in and out of the compound.

The Council apologised for failing to advise him by letter and the contractors appointed a gangster to assist him when walking back and fore to his garage.

The Council agreed to:

- a) make a redress payment of £10 (the equivalent of 2 week’s rental) to him in recognition of its failure to warn him by letter of the impending works
- b) Consider comparable actions in response to any other individuals with similar circumstances.

This was to be completed within two months of the date of the decision letter.

Cardiff Council - Poor/No communication or failure to provide information

Case Number 201604753 – Report issued in January 2017

Mr A complained that he witnessed a Council employee driving dangerously. He made a complaint to the City of Cardiff Council, (the Council”) however it failed to notify him when its investigations were complete.

On receipt of the complaint the Ombudsman was of the view that whilst the Council is not able to give specific detail on what action, if any, it has taken, it should provide Mr A with confirmation when its investigation is/ was completed.

The Council confirmed that it would do this.

More information

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

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

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