

The Ombudsman's Casebook

Issue 32 May 2018

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News

Spring Seminar Held

In February, the Ombudsman Spring Seminar took place at the Metropole in Llandrindod Wells.

The theme for the day was complaints culture in the public sector, looking at how complaints can be used as a learning tool and the importance of complying with recommendations

Speakers included ABMU Chief Executive Tracy Myhill, WLGA Chief Executive Steve Thomas and Public Health Wales' Chris Hancock who is leading the 1000 Lives Acute Deterioration project.



Assembly Agrees General Principles of Ombudsman Bill

In March, following a plenary session, the National Assembly for Wales voted 47-1 in favour of the general principles of the Public Services Ombudsman (Wales) Bill

A financial resolution must now be passed by the Cabinet Secretary for Finance before Stage 2 of the legislative process begins, hopefully in the coming months

Health

Upheld

A dental practice in the area of Hywel Dda University Health Board

Case Number 201606411 – Clinical treatment outside hospital – Report issued in January 2018

Mr A complained that a dental practice in the area of Hywel Dda University Health Board (“the Practice”) had fitted his original dental crown (“the crown”) incorrectly. He also said that it had subsequently failed to address that clinical error appropriately.

The Ombudsman determined that the early loosening of Mr A’s crown indicated that there was a preparation and/or installation fault. He therefore upheld that part of Mr A’s complaint, which concerned the fitting of his crown. He found that the Practice did not address Mr A’s crown-related difficulties promptly or diagnose the cause of his crown failure. He upheld that aspect of Mr A’s complaint, which concerned the management of his crown-related problems, as a result.

He recommended that the Practice should

- a) apologise to Mr A for the failings identified
- b) pay him £356.60; this payment consists of a treatment cost refund and a sum for inconvenience
- c) formally remind its Dentists to investigate and address the failure of newly fitted crowns promptly
- d) prepare an action plan, which outlines the steps that it will take in an effort to ensure that X-rays are not mislaid.

The Practice agreed to implement these recommendations.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201700166 – Report issued in January 2018

Mrs A complained that there had been a delay in diagnosing her illness and that there had been a failure to adequately respond to her complaint in accordance with the “Putting Things Right” regulations.

The investigation found that there had been a failure to examine Mrs A for a period of four days which may have resulted in a missed opportunity to diagnose Mrs A’s condition. Additionally, further delays resulted from Hywel Dda University Health Board’s (“the Health Board”) failure to have access to MRI scanning facilities over the weekend period. The investigation also found that the Health Board failed to respond to Mrs A’s complaint within the timeframe specified by the Regulations.

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

- a) apologise to Mrs A
- b) make a payment of £125 for the time and trouble of bringing her complaint to this office and, £500 in recognition of the identified delays
- c) share the Ombudsman’s report with the relevant clinicians during their next supervision session and that areas for learning are identified and shared within the relevant department.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201606216 – Report issued in January 2018

Mrs A complained about the care and treatment her late father, Mr B, received from Betsi Cadwaladr University Health Board (“the Health Board”) between 13 October and 23 November 2015, when Mr B sadly died. Mrs X said that the Health Board had failed to adequately communicate with the family or maintain records. Mrs A also complained that there had been a failure to meet Mr B’s basic nutrition and hydration needs and that allegations that Mr B was a victim of domestic abuse had not been acknowledged. Finally,

Mrs A complained that there had been a failure to appropriately respond to the complaint.

The investigation found that there had been a general failure on the part of the clinicians to keep Mr B's family informed of his treatment, care and prognosis. The investigation also found failings in the standard of record keeping which resulted in it not being possible to conclude whether Mr B's nutritional needs were being met and, the Health Board providing an inaccurate and inconsistent complaint response which added to the distress experienced by Mr B's family. Finally, the investigation found that having been informed on 13 October 2015 that Mr B was the victim of domestic abuse, the Health Board took appropriate safeguarding action to protect Mr B.

It was recommended that the Health Board:

- a) apologise to Mrs A for the failings identified in the report
- b) pay the sum of £250 in recognition of those failings and the sum of £250 for the time and trouble Mrs A experienced bringing her complaint to this office.
- c) remind investigation staff of the need to check for accuracy in its response letters;
- d) remind nursing staff to clearly record when a record has been written in retrospect, to prevent any confusion; and finally
- e) undertake a review of this case with the relevant clinicians during their next supervision session.

Betsi Cadwaladr University Health Board – Patient List Issues Case Number 201606896 – Report issued in January 2018

Mr P complained that Betsi Cadwaladr University Health Board's ("the Health Board") scheduling of a total knee replacement operation that he required significantly exceeded the Welsh Government's 36-week referral-to-treatment (RTT) time target for NHS organisations in Wales. At the time of his complaint to the Ombudsman, Mr P had been on a waiting list for 84 weeks and was still awaiting a date for his surgery. Mr P also complained that:

1. A Consultant Orthopaedic Surgeon, who initially assessed him, agreed that he required knee-replacement surgery, but did not initially place him on a waiting list. Instead, he opted to administer a steroid injection and to review Mr P in four months
2. At the review, the Consultant told Mr P that there was nothing wrong with him and that he should "go home, take a couple of paracetamol and stop making a fuss"
3. Following a request for a second opinion, a second Consultant Orthopaedic Surgeon conducted a specialised form of X-ray which the first Consultant had failed to do. The X-ray result led the second Consultant to immediately place Mr P on a waiting list for a total knee replacement
4. The Health Board failed to arrange anaesthetic and cardiology assessments for Mr P in a timely manner
5. The Health Board failed to respond to his letter of 6 February 2017 in which he requested information about the type of anaesthetic that he would receive.

The Ombudsman, assisted by his Clinical Adviser, upheld complaints 3 and 5. He found that the failure of the First Consultant to arrange a specialised form of X-ray for Mr P led to an avoidable 13-week delay in him being placed on the waiting list. The Ombudsman also found that the Health Board failed to respond to Mr P's letter of 6 February 2017. The Ombudsman could not reach a finding on complaint 2 and did not uphold complaints 1 and 4.

The Ombudsman recommended that the Health Board:

- a) provide Mr P with a fulsome apology for the identified failings
- b) pay him £500 in recognition of the injustice that they gave rise to
- c) remind orthopaedic physicians based at CMATS that Rosenberg X-rays should be used as standard for investigating patients presenting with potential knee osteoarthritis whose routine X-rays are inconclusive.

Whilst the Ombudsman expressed his concern at the extent to which the Health Board's scheduling of Mr P's surgery exceeded the 36-week RTT time target, he could not uphold this failing as it equally applied to all orthopaedic patients awaiting surgery.

However, the Ombudsman recommended that the Health Board

- a) provide him with an update on the development of its strategic action plan for orthopaedic services
- b) and provide details of its 'delivery plan' for all patients who have waited over 52 weeks.

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

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201605348 – Report issued in January 2018

Mrs X complained about the care and treatment her late brother, Mr Y, received at the Royal Gwent Hospital between 23 and 28 May 2015 when, sadly, he died. She complained about poor nursing care and monitoring, inadequate pain relief, decisions regarding anxiety medication and clinical investigations and the Health Board's complaint handling. Mrs X complained that, because of these failings, Mr Y's family were left to provide much of his care and Mr Y experienced avoidable pain and distress during his final days.

The Ombudsman did not uphold the complaints about anxiety medication and clinical investigations. The Ombudsman partially upheld the complaints about nursing care and pain relief. The Ombudsman fully upheld the complaints about monitoring. The Ombudsman concluded that inadequacies in monitoring of Mr Y's deteriorating condition resulted in a delay in the commencement of appropriate treatment and left his family with uncertainty as to whether the sad outcome might have been different.

The Health Board agreed the Ombudsman's recommendations to:

- a) apologise to Mr Y's family
- b) to review the inadequacies in its own complaint investigation
- c) to undertake recordkeeping audits; and
- d) to take remedial action in response to the failings identified in this respect.

Hywel Dda University Health Board, Cardiff & Vale University Health Board and a GP practice in the area of Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Numbers 201700624, 201700623 and 201700625 – Report issued in January 2018

Mrs S's complaint against:

- a) Hywel Dda:
 - the way in which GP referrals to general surgeons were handled, leading to delay in the diagnosis of a hernia
 - the failure to refer Mr S to the liver unit at a Cardiff & Vale hospital sooner
- b) Cardiff & Vale – the delay/failure by the liver unit in diagnosing angiosarcoma
- c) The GP practice – the management of referrals to Hywel Dda, causing delay in the diagnosis of a hernia.

The Ombudsman found that the redirection of the referral to general surgery was not unreasonable, although Mr S and the GP should have been informed of this; there was no unreasonable delay in the referral to the liver clinic. He did not uphold the complaint against Hywel Dda.

The Ombudsman found that the liver unit should have itself organised a repeat scan, rather than requesting Hywel Dda carry it out; angiosarcoma might have been diagnosed some two months earlier than it was, and the Ombudsman upheld the complaint against Cardiff & Vale. However, this short delay was unlikely to have affected the outcome for Mr S.

The Ombudsman found that the GP's first referral to Hywel Dda was appropriate and timely. However, this was not the case with the follow-up referral; it was delayed, and contained inadequate information to explain why an urgent appointment was being requested. He concluded that it was likely that Mr S would have been seen (and a hernia diagnosed) sooner if all relevant information had been included, and upheld the complaint against the GP practice. However, it was unlikely that Mr S would have had surgery to repair the hernia before liver surgery took priority.

The Ombudsman recommended that Cardiff & Vale apologise to Mrs S and that members of the multi-disciplinary team reflect on the matter and consider whether its procedures should be reviewed. He recommended that the GP surgery also apologise to Mrs S, and provide evidence that the actions it had already identified had been carried out.

Welsh Ambulance Services NHS Trust – Ambulance Services

Case Number 201607364 – Report issued in January 2018

Mr K complained about the failure of the Welsh Ambulance Services NHS Trust ("WAST") to respond promptly and urgently to a series of calls when his wife became ill with chest pain and breathing difficulties. Sadly, Mrs K died before an ambulance arrived.

The Ombudsman found that there had been errors in the coding of some of the calls made by Mr K and by WAST to him; if they had been coded correctly, it was possible that an ambulance might have arrived with Mrs K approximately three – four minutes earlier. Although the Ombudsman could not say with certainty that the outcome would have been different, Mr K was left with a degree of uncertainty of not knowing whether Mrs K might have survived if help had arrived sooner. The Ombudsman upheld the complaint.

The Ombudsman recommended WAST:

- a) apologise again to Mr K
- b) make a payment of £750 to him in recognition of the uncertainty caused by the failings identified; and
- c) further reflection by the member of staff involved, and consideration of a review of WAST's processes.

Hywel Dda University Health Board – Continuing Care

Case Number 201700459 – Report issued in January 2018

Amongst the issues that Mr A complained about were shortcomings in his late wife's care package. This included a delay in a replacement care co-ordinator being appointed and a new care package being put in place. Mr A was also dissatisfied with the handling of his complaints by Hywel Dda University Health Board ("the Health Board").

The Ombudsman did not uphold any part of Mr A's complaints apart from that relating to complaint handling. The Ombudsman concluded that administrative shortcomings meant the Health Board's handling of Mr A's complaints were not as effective or co-ordinated as they could have been and as a result there was an undue delay in the Health Board providing a formal response to Mr A's complaints.

The Ombudsman recommended that the Health Board's Chief Executive:

- a) apologise to Mr A for the failings;
- b) and make a payment to him of £250.00.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201607481 – Report issued in January 2018

Mrs A had concerns that a series of diabetic hypoglycaemic episodes that her late mother, Mrs B, suffered while an inpatient at Ysbyty Alltwen in May 2015 had affected her heart and led to her suffering a heart attack from which she subsequently died. She was also dissatisfied with the Health Board's handling of her complaint.

The Ombudsman's investigation concluded that Mrs B's hypoglycaemic episodes might have contributed to her heart attack but this could not be said for certain, given that she had risk factors for cardiovascular disease - high blood pressure and diabetes - and a scan of her heart prior to the hypoglycaemic episodes had suggested her cardiac function was already impaired. Given the uncertainty, the Ombudsman upheld this part of Mrs A's complaint. The Ombudsman also identified shortcomings in Betsi Cadwaladr University Health Board's ("the Health Board") handling of Mrs A's complaint and upheld this part of her complaint.

The Ombudsman's recommended that the Health Board:

- a) apologise to Mrs A for the failings identified
- b) make a payment of £750 to her, given the uncertainty caused by the shortcomings in clinical care and the impact inadequacies in complaint handling had had on her.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201606395 – Report issued in January 2018

Mr A, who underwent a kidney transplant in 1998 at another hospital, complained that during his inpatient admission in 2015 at the Royal Gwent Hospital he was placed on a ward where there was an outbreak of norovirus which he contracted. He said he continued to have vomiting and diarrhoea on discharge and the norovirus caused his kidney transplant to fail. Mr A was also dissatisfied that contact had not been made with the renal consultant at the other hospital responsible for his renal care and that his paper medical/nursing records had been lost.

The Ombudsman could not say that Mr A had contracted norovirus at the Hospital. Clinical and administrative failings (around record keeping, clinical nursing assessments and compliance with the National Institute for Health Care Excellence guidelines on acute kidney injury) meant there was uncertainty about whether Mr A would, if not for the failings identified, have had more time before his kidney transplant failed, given he had chronic kidney function. In light of this uncertainty, Mr A's complaint was to this extent only upheld.

The Ombudsman found administrative failings associated with the loss of Mr A's medical records had adversely impacted on Mr A's confidence in Aneurin Bevan University Health Board's ("the Health Board") complaint response. He therefore upheld this part of Mr A's complaint.

The Ombudsman's recommendations included the Health Board:

- a) apologising
- b) making a payment of £500 for the uncertainty/failings;
- c) and evidencing actions taken in part as a result of the Ombudsman's investigation.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number 201606209 – Report issued in January 2018

The investigation considered whether the care and treatment provided to Mr Y following referral from another Health Board was reasonable, including the discussions surrounding the risks of surgery and the choice of surgery offered. It also considered the decision not to carry out planned surgery in July 2016.

The Ombudsman found that whilst the care and treatment following referral was reasonable as was the choice of surgery, he was unable to conclude with any certainty that the discussion of risk was appropriate due to the inadequacy of records. Whilst he acknowledged this was maladministration, it did not cause Mr Y an injustice as the surgery did not go ahead. He did not uphold this complaint.

The Ombudsman also found that whilst the decision not to carry out the planned surgery was justified, Mr Y could have been better informed about the decision (the Surgeon gave two contrasting reasons for his decision). He also found that the waiting list card (detailing the operation Mr Y was listed for) was only rectified after Mr Y had contacted Cardiff and Vale University Health Board.

The Ombudsman partially upheld the complaint to the extent that the way the decision was communicated to Mr Y meant there was uncertainty surrounding the grounds for the Surgeon's decision and that contact from Mr Y to confirm the surgery he was listed for was justified.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number 201603422 – Report issued in January 2018

Mrs Y complained on behalf of her daughter, Ms X, about the maternity care Ms X received following the spontaneous rupture of her membranes ("SRM") in May 2016. Mrs Y also complained that the care provided to Ms X's new born child (baby X) was unsatisfactory. She complained that when she expressed concerns to staff, these were not appropriately responded to.

The Ombudsman found that aspects of Ms X's care were reasonable. However, there were shortcomings, the most significant of which was the number of vaginal examinations ("VE") performed before Ms X was in established labour. He also found that an invasive 'stretch and sweep' was not appropriate. These would have caused Ms X increased pain and discomfort. Whilst there was a small increase in the risk of infection from multiple VEs, the Ombudsman was unable to conclude with any certainty that Ms X would have avoided infection but for the unnecessary VEs.

In terms of baby X's care, the Ombudsman found that the overall care provided was satisfactory. Whilst he was unable to be definitive on whether Aneurin Bevan University Health Board's ("the Health Board") actions may have contributed to Mrs X's infection and hence an infection for baby X, he found that the uncertainty caused around these events represented an injustice. The Ombudsman was unable to reach a judgement regarding the concerns Mrs Y expressed.

The Ombudsman made several recommendations to the Health Board including an apology, financial redress, and guidance updates to relevant staff regarding SRM.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201607149 – Report issued in January 2018

Mrs X complained about the treatment her mother Mrs Y received at the Transient Ischaemic Attack (stroke) clinic, Neville Hall Hospital on 7 April 2016.

The Ombudsman found that on 7 April there was no evidence to support Mrs X's diagnosis of vertigo and that she should have had a CT head scan to exclude an intracerebral bleed (a blood vessel within the skull ruptures or leaks); he upheld these aspects of the complaint. The Ombudsman found that Mrs Y's

dehydration should have been further investigated and he partly upheld this aspect of the complaint. The Ombudsman found that Aneurin Bevan University Health Board's ("the Health Board") explanations that, had Mrs Y's GP suspected she suffered a stroke, an ambulance would have been called and that Mrs Y was seen by a health community support worker (HCSW) and not a stroke nurse as Mrs Y assumed, were reasonable. He found that the HCSW's entry on the patient information leaflet had caused confusion; he did not uphold these aspects of the complaint.

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

- a) apologise to Mrs Y for the identified failings;
- b) and to remind TIA clinic staff that blood tests should be carried out when there are concerns to prevent acute kidney injury.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201700880 – Report issued in January 2018

Mrs B complained about

- The delay in treatment of her father, Mr C, following his diagnosis with bladder cancer, and delays in his subsequent follow-up.
- The delay in carrying out her father's (unrelated) prostate surgery.

The Ombudsman found that Mr C had experienced delays in his cancer treatment for a number of reasons, some of which were administrative and some due to staff shortages. However, the initial delay related to the beginning of treatment following Mr C's diagnosis – the treatment was not planned to begin until after a further investigation, which meant a delay of over three months before the treatment which it had been decided Mr C needed began. There were also delays in carrying out the prostate surgery. The Ombudsman upheld the complaint.

He recommended that Betsi Cadwaladr University Health Board:

- a) apologise to Mr C
- b) make a payment of £600 to him in recognition of the additional distress and suffering caused by the delays.
- c) He noted improvements which the Health Board said it had made, and recommended an assessment of the impact of these should be carried out.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201700674 – Report issued in January 2018

Mrs T complained about the treatment provided to her late husband, Mr T, from 21 to 23 November 2014 at Morriston Hospital ("the Hospital"). Mrs T was concerned that Mr T had been administered with Heparin (blood thinning medication) despite being at risk of suffering a brain haemorrhage (when an artery inside the brain bursts). Mrs T also complained that Mr T had not been sufficiently monitored, and that the Health Board had failed to provide her with the exact time that Mr T had suffered a brain haemorrhage. Mrs T was also concerned that the Health Board had been unable to locate some of her husband's medical records and was dissatisfied with the efforts that had been made to locate them.

The Ombudsman found that it had been reasonable to treat Mr T with Heparin, and that he had been appropriately monitored. These elements of the complaint were not upheld. It was not possible to ascertain the exact time that Mr T suffered a brain haemorrhage; however, the Ombudsman upheld this aspect of the complaint as Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to provide accurate information to Mrs T regarding the timing of his deterioration, even though accurate information was contained within the medical records. The Ombudsman also upheld the complaint relating to the missing medical records as it had misinformed Mrs T that it had been unable to find the nursing records. The Health Board had since realised that nursing notes had not been completed at the Hospital for the specified date as Mr T was in another hospital, and, therefore had never been missing.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mrs T for the failings identified
- b) make a redress payment of £750 in total, to reflect the distress she suffered when she was misinformed that Mr T's nursing records were missing and the incorrect information she was given regarding his deterioration
- c) take steps to ensure that staff involved in investigating and responding to complaints conduct robust investigations and provide complainants with clear and accurate information.

The Health Board agreed to implement these recommendations.

Betsi Cadwaladr University Health Board

Case Number 201701156 – Report issued in February 2018

Mr Y complained about the cancer care and treatment he received from Betsi Cadwaladr University Health Board ("the Health Board"), from his diagnosis in 2012 to May 2016. Part of the complaint was upheld.

The investigation found that, overall, the treatment provided to Mr Y was conducted to a reasonable standard and that Mr Y was appropriately advised of his treatment plan. However, there was an unreasonable delay of 31 days from referral to bowel cancer treatment in 2012. Whilst it was not possible to conclude with certainty, it was considered that the delay may have contributed to a worse long-term outcome for Mr Y. The investigation also found that, due to an administrative error, there had also been a delay in referring Mr Y for a procedure in 2016. However, this element of the complaint was not upheld as there was no evidence that the error had an adverse impact upon Mr Y.

In relation to the unreasonable delay in 2012, the Ombudsman recommended that the Health Board should apologise to Mr Y's wife for the uncertainty caused by the delay from his referral to treatment and to provide the Ombudsman with an assurance, outlining how the Health Board will ensure that such delays are prevented in future.

Cwm Taf University Health Board – Clinical treatment outside hospital

Case Number 201606175 – Report issued in February 2018

Ms T complained about the emergency dental treatment that she received from Cwm Taf University Health Board ("the Health Board"). She said that the Dentist involved ("the Dentist") did not enable her to give informed consent to the removal of her tooth. She also suggested that he might have removed that tooth unnecessarily. Ms T also complained about the Health Board's response to her complaint about her dental treatment. She reported that it did not interview the Dental Nurse involved ("the Dental Nurse") in her treatment when it investigated her complaint. She also said that it took too long to provide its response to her complaint.

The Ombudsman found that the Dentist enabled Ms T to give informed consent to the removal of her tooth. He also determined that the Dentist had not removed Ms T's tooth unnecessarily. He did not uphold that part of Ms T's complaint which concerned her dental treatment. He determined that the Health Board's response to Ms T's complaint was unreasonably delayed. He also found that the Health Board did not obtain a written statement from the Dental Nurse during its investigation of it. He partly upheld that aspect of Ms T's complaint which concerned complaint handling.

He recommended that the Health Board should:

- a) apologise to Ms T for the complaint handling failings identified
- b) take action to ensure that complaints, which are received directly by its Primary Care Team, are processed in accordance with the relevant time frames.

The Health Board agreed to implement these recommendations.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201600871 – Report issued in February 2018

Mr A complained about the care given to his late mother, Mrs A, by Cwm Taf University Health Board (“the Health Board”). He raised concerns about her gynaecological care, her cardiac treatment and other issues. He indicated that the Health Board had not addressed Mrs A’s post-menopausal bleeding (“PMB”) properly. He also contended that it had not taken its decision to remove Mrs A’s womb correctly. He said that the Health Board had given Mrs A a permanent pacemaker (“PPM”) unnecessarily. He asserted that it had not offered Mrs A, or her family, appropriate support in relation to her heart condition. He also indicated that its management of that condition had been lacking in several ways. He said, in terms of other issues, that the Health Board had not treated Mrs A’s skin infection, that it had discharged her from hospital with anaemia and that it had failed to investigate why blood had been found in her urine.

The Ombudsman found that the Health Board had responded appropriately to Mrs A’s PMB. He was satisfied that the Health Board had taken its decision to remove Mrs A’s womb correctly. He also determined that that decision was reasonable. He did not uphold that aspect of Mr A’s complaint, which concerned Mrs A’s gynaecological care. He found that it had been clinically necessary for the Health Board to insert Mrs A’s PPM. He also considered that the support arrangements made for Mrs A and her family, because of her heart condition, had been clinically appropriate. However, he determined that the Health Board’s management of Mrs A’s heart failure symptoms and her related discharges from hospital had been deficient. He partly upheld that element of Mr A’s complaint, which concerned Mrs A’s cardiac treatment. He found that the Health Board had effectively treated Mrs A’s skin infection. He confirmed that it had discharged Mrs A from hospital with anaemia. He also noted that it had not taken prompt action to address that condition. He determined that the Health Board’s response to the blood found in Mrs A’s urine had been inadequate. He partly upheld that aspect of Mr A’s complaint, which concerned the other issues identified as a result.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mr A for the failings identified
- b) submit a related action plan and a formal undertaking to complete the actions specified within it.

The Health Board agreed to implement these recommendations.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201606699 – Report issued in February 2018

Miss X complained about the care her mother (“Mrs Y”, who had been diagnosed with liver disease many years previously) received over several months following her admission to two of the Health Board’s hospitals in September 2015. She was concerned that the medication prescribed to her mother might have aggravated her liver condition. She was also concerned that her mother’s liver condition was not considered when treating her, a connection was not made that the symptoms she displayed might have been linked to her liver condition, and that appropriate and timely investigations were not carried out to monitor her mother’s liver function, specifically that there was a delay in carrying out a liver scan. Mrs Y sadly died in March 2016.

The Ombudsman found that Mrs Y was not prescribed medication that was contra-indicated for her liver condition. However, he concluded that, when Mrs Y displayed signs consistent with a deterioration in liver function, clinicians did not act on these as soon as they should have, and as a result, there was a delay in Mrs Y undergoing a scan. Whilst, on balance, this would not have changed the outcome for Mrs Y, it meant that there was a delay in Mrs Y receiving supportive treatment. There was also, as a result, a missed opportunity to communicate the seriousness of Mrs Y’s condition to both Miss X and Mrs Y. The Ombudsman found that this caused them both an injustice and upheld these complaints.

He recommended the Health Board should

- a) apologise for the shortcomings; and
- b) present the case at a Directorate meeting to consider further training.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201606898 – Report issued in February 2018

Ms X complained about Hywel Dda University Health Board's ("the Health Board") care and treatment of her mother, Mrs Y, while she was an inpatient from 1 May to 14 July 2015. Ms X specifically complained about Mrs Y's fall on 18 May and her subsequent care and treatment for her injury, the Health Board's decision and management of Mrs Y's transfer to a Care Home including its failure to properly engage with both Ms X and Mrs Y about this, and the Health Board's diagnosis, management and lack of communication about Mrs Y's dementia diagnosis.

The investigation found some shortcomings in Mrs Y's falls risk, delay in identifying her injury and a lack of communication between clinicians about Mrs Y's diagnosis in terms of her fall and dementia; however, ultimately there was no clinical impact to Mrs Y in terms of outcome. When Mrs Y's injury was confirmed she received the appropriate care and treatment. Based on the evidence provided, Ms X's complaint about Mrs Y's fall and her dementia diagnosis were partly upheld to the extent of any uncertainty and distress caused to Ms X. Ms X's complaint about Mrs Y's transfer to a Care Home was not upheld.

The ombudsman recommended that the Health Board:

- a) Formally apologise to Ms X for the uncertainty and distress caused to her by its management of Mrs Y's falls and subsequent fractured hip
- b) Remind staff of the importance of following its new Preventing Falls and Post Fall Care in Inpatient Area Policy across all inpatient areas
- c) Consider whether the use of multi-professional notes could improve communication between nursing and medical teams
- d) Remind nursing staff involved in Mrs Y's care to:
 - i. Record on Datix every incident and keep the medical team apprised of any serious events such as a fall.
 - ii. Complete patients' discharge/transfer checklists
- e) Introduce a 'medical communication book' where any concerns about a patient's diagnosis raised with nursing staff, or other members of a MDT, are recorded and raised with the patient's medical team.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201607196 – Report issued in February 2018

Mrs N complained about the care and treatment she received from Betsi Cadwaladr University Health Board ("the Health Board"). Mrs N said she wasn't referred for a CT scan following a hysteroscopy in July 2014 and was incorrectly examined for an anal fistula when she had been referred for a pilonidal sinus in February 2016.

The investigation found that Mrs N was assessed appropriately in July 2014 and that it was reasonable she was not referred for a CT scan based on the hysteroscopy and the tests carried out. The investigation also found that prior to Mrs N's examination in February 2016, she underwent an MRI scan that did not exclude her having a pilonidal sinus. Due to this omission, Mrs N's pilonidal sinus was not removed until June 2016. This delay of four months was deemed unnecessary.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mrs N for the unnecessary delay, and
- b) make a payment of £400 in recognition of the delay and the distress she endured.

Hywel Dda University Health Board – clinical treatment in hospital

Case Number 201607714 – Report issued in February 2018

Mrs X complained that Hywel Dda University Health Board (“the Health Board”) in 2014 failed to diagnose her mother’s (“Mrs A”) fractured leg and its subsequent care of her knee was inappropriate. Mrs X also complained about the management of her complaint.

The investigation found that the Health Board failed to interpret and diagnose Mrs A’s fracture appropriately and that she was left in a position of trying to mobilise on a fracture which caused pain.

The investigation also found that although Mrs A’s management plan was appropriate, the delay in treating her fracture caused additional distress and discomfort until an appropriate management plan was put in place. The complaint was upheld.

Mrs X was initially kept reasonably informed about her complaint, particularly as another department was involved. However, the investigation found by September 2016 no response was forthcoming and the complaint was upheld due to the time and trouble Mrs X experienced in pursuing her complaint from that time.

The Ombudsman recommended an apology, nominal redress and a change in process. The Health Board accepted the recommendations.

Betsi Cadwaladr University Health Board and a GP Practice in the area of the Health Board

Case Number 201700179 & 201700218 – Report issued in February 2018

Mrs P complained that a GP from the Practice failed to diagnose a serious leg infection and admit Mr P to hospital on 23 December 2015. Mrs P also raised concerns about the care given by the Out of Hours (“OOH”) GP service provided by Betsi Cadwaladr University Health Board (“the Health Board”). Mrs P complained that, on 27 December, there was a failure to diagnose possible sepsis (also referred to as blood poisoning and a potentially life-threatening condition, triggered by an infection or injury) or necrotising fasciitis (a bacterial infection that affects the tissue beneath the skin and surrounding muscles and organs) and admit Mr P to hospital. Mrs P was also concerned that there had been a delay in arranging for Mr P to be admitted to hospital on 28 December, and a lack of urgency in requesting a response from the Welsh Ambulance Service Trust having recognised that he was seriously unwell. Mr P sadly died on 29 December following his admission to hospital the previous day.

The Ombudsman was satisfied that the assessment and management of Mr P’s condition on 23 December by the GP was of a reasonable standard and that the action taken in not admitting Mr P to hospital was appropriate. The Ombudsman was unable to reach a finding on whether the OOH GP should have admitted Mr P to hospital on 27 December. Whilst there was evidence that a discussion regarding hospital admission had taken place, precisely what was explained to Mr P and whether Mr P was given sufficient information to make an informed decision was unclear. It was recorded that Mr P had declined to be admitted. The Ombudsman upheld Mrs P’s complaint that there was an unreasonable delay by an OOH GP in admitting Mr P to hospital on 28 December, and found that he could have been admitted three hours earlier.

The Ombudsman recommended the Health Board:

- a) provide Mrs P with a written apology
- b) provide a redress payment for this failure; however, no redress payment was made in accordance with the views of Mrs P.

Finally, there was no evidence of a delay in an ambulance being arranged on 28 December, and this element of Mrs P’s complaint was not upheld.

Abertawe Bro Morgannwg University Health Board

Case Number 201606802 - Report issued in March 2018

Mrs X was diagnosed with advanced vascular dementia. On 25 January 2016, she was admitted to the Princess of Wales Hospital ("the hospital") under Section 2 of the Mental Health Act 1983 (detained for assessment and treatment of mental health disorder). Mrs X was transferred to Cefn Coed Hospital where she remained, by virtue of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards. Mrs X was discharged home on 29 March where she died on 29 August. Mrs Y complained that her mother's medications were not correctly recorded between 6 and 24 March. Mrs Y also complained about Mrs X's discharge.

The Ombudsman found Mrs X's medication regime was reasonable, but medication administered as required ("PRN") was not always named on the nursing notes and once, it had not been recorded on the prescription charts. He partly upheld this part of the complaint. The Ombudsman found that Mrs X's should have returned to the hospital after weekend leave and a formal discharge meeting taken place; occupational therapy and home care assessments should have been undertaken, and a multidisciplinary meeting held to determine continuing health care ("CHC") funding. The Health Board agreed to implement the Ombudsman's recommendations and apologise to Mrs Y for failing to provide information about assessments after Mrs X's discharge, ensures staff are reminded to name administered PRN medication, highlight that PRN medication was not recorded on the prescription charts, and discharge planning meeting should be held before patients are discharge with information about how CHC funding arrangements will proceed.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number 201702148 - Report issued in March 2018

Mr F complained about the care and treatment he received from Cwm Taf University Health Board ("the Health Board"). In particular he said the Health Board failed to refer him for further scans and treatment on two occasions when he expressed concerns about his eye drooping: he was subsequently diagnosed with mantle cell lymphoma (MCL). He also said that the Health Board treated him for glaucoma when, subsequently, he was told he did not have it.

The investigation found that there was no written record of Mr F raising concerns about his drooping eye during two clinic appointments, and the clinicians involved did not recall their conversations with Mr F. Without independent corroborative evidence, the Ombudsman could not make a finding on this aspect of the complaint. The investigation also found that the treatment Mr F received for glaucoma prior to his diagnosis of MCL was reasonable, and the medication he was prescribed was appropriate based on his presenting symptoms at the time. The Ombudsman did not uphold this complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201606906 - Report issued in March 2018

Mrs C complained about the care and treatment her mother, Mrs B, received when she suffered a fall at home. She said that Betsi Cadwaladr University Health Board ("the Health Board") failed to ensure that Mrs B's injury remained stable, to provide adequate care to Mrs B whilst she was on the ward and that on arrival at hospital Mrs B was kept in ambulance for an excessive amount of time without a clinical assessment.

The Ombudsman upheld Mrs C's complaint that the Health Board failed to provide adequate care whilst Mrs B was on the ward. Staff did not adequately monitor Mrs B, neither was there sufficient information in the records to show that staff responded to concerns raised about her condition. He found that due to the lack of monitoring and poor record keeping it was not possible to know whether action could have been taken to avoid Mrs B's deterioration and this was an injustice to Mrs C.

The Ombudsman found that Mrs B's spinal care was reasonable but, he was unable to make a finding in relation to whether Mrs B's injury was adequately stabilised. The Ombudsman also found that the Health Board did not assess Mrs B in a reasonable amount of time on her arrival at hospital, and relied upon ambulance staff to provide care for which the Health Board was responsible.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mrs C for the failings identified in the report
- b) pay redress of £2250
- c) remind Emergency Department staff of the appropriate timescales for assessing patients;
- d) remind staff involved in the case of the importance of good record keeping and that they review this case with their supervisor to ensure lessons have been learned; and
- e) audit practices and introduce a programme of protocol updates and a system for recording mandatory training.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201700598 - Report issued in March 2018

Ms H complained about the standard of hospital nursing care provided to her late grandmother, Ms A, between September and the end of December 2015, prior to her death. Ms H raised concerns about the treatment and management of infections around Ms A's Percutaneous Endoscopic Gastronomy ("PEG", a feeding tube which is passed into the stomach directly through the abdominal wall) feeding tube site. Ms H also said that poor nursing care contributed to the deterioration in Ms A's health.

The Ombudsman found that the standards of nursing care fell below the level expected. He also found there was no evidence that Ms A's PEG site was inspected or cleaned daily and there was a delay in treatment following the result of a positive MRSA (a type of bacteria that is resistant to several widely used antibiotics) swab. There was also a lack of documentation in relation to appropriate infection control management. These complaints were upheld. There was no definitive evidence to suggest that the standard of nursing care contributed to Ms A's deterioration prior to her death and this element of the complaint was not upheld.

The Ombudsman considered the failures in service constituted an injustice to Ms A and Ms H. He recommended that Aneurin Bevan University Health Board ("the Health Board"):

- a) apologise to Ms H
- b) provide her with a redress of £500 for the distress experienced as a result of the shortcomings identified
- c) provide evidence to support the improvements it said that it had already made following its own investigation
- d) undertake an audit of its individualised care plans and provide evidence of a care plan or pathway for the management and treatment of patients with MRSA.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201607091- Report issued in March 2018

Mr A complained that Hywel Dda University Health Board ("the Health Board") made a surgical error during his hernia repair operation. He said that his bowel had become blocked as a result.

The Ombudsman determined, on the balance of probability, that a surgical failing had caused Mr A's hernia to recur. He also found that that recurrence had led to the blockage of Mr A's bowel. He upheld Mr A's complaint. He recommended that the Health Board should:

- a) apologise to Mr A for the surgical deficiency identified
- b) pay Mr A £750 in recognition of the additional suffering and distress that he had experienced because of this failing.

The Health Board agreed to implement these recommendations.

Betsi Cadwaladr University Health Board – De-registration

Case Number 201607374 - Report issued in March 2018

Mr D complained that Betsi Cadwaladr University Health Board (“the Health Board”) failed to adequately investigate a complaint that he made against his GP Practice about its decision to deregister him on grounds of unacceptable conduct. Mr D complained that the Health Board failed to conduct its investigation in accordance with relevant PTR Regulations and, in deciding not to uphold his complaint, failed to have regard to regulations governing the deregistration of patients. Mr D also complained that the Health Board:

- accepted, without question, the version of events provided by the Practice and failed to interview him or to obtain his comments on statements made by Practice personnel
- failed to provide an adequate response to a letter that Mr D submitted in response to the Health Board’s investigation report
- failed to respond to a further letter that he sent, in which he offered to provide a recording he had made of a telephone conversation with a GP at the Practice.

The Ombudsman found that, whilst the Health Board’s investigation broadly adhered to PTR Regulations, it significantly exceeded the 30-working day timeframe for issuing its response. The Ombudsman also found that the Practice did not correctly follow the deregistering process and that this was not identified by the Health Board in its investigation.

The Ombudsman did not uphold Mr D’s complaint that the Health Board failed to interview him or to obtain his comments on statements made by Practice personnel, as this is not a requirement of the Health Board’s investigation procedure. However, the Ombudsman did uphold Mr D’s complaint that the Health Board failed to respond to a follow up letter that he submitted after receiving the investigation report and failed to respond to a further letter that Mr D sent, in which he offered to provide a recording he had made of a telephone conversation with a GP at the Practice. The Ombudsman found that the Health Board did not deal adequately with the offer of considering the recording and suggested that this was because it had not developed a policy for dealing with covert recordings of this kind.

The Ombudsman recommended that:

- a) The Health Board provide Mr D with a written apology for the identified failings and makes a payment to him of £250
- b) The Health Board provides PCSU officers with refresher training in regard to the regulations governing the deregistration of patients
- c) The Health Board reminds PCSU officers of the need to ensure that investigations are compliant with its Standard Operating Procedure and with timescales set down in PTR Regulations
- d) The Health Board shares this report with the GP Practice, requesting that personnel review and reflect on the failings identified in the deregistration process.
- e) The Health Board takes steps to develop a policy for managing and regulating its response to the covert recording of interactions between complainants/patients and NHS personnel.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201700027 - Report issued in March 2018

Mrs X complained about the care and treatment her late husband, Mr X, received from Betsi Cadwaladr University Health Board (“the Health Board”) in June 2014. In particular Mrs X said that appropriate action was not taken following his diagnosis of sepsis; the Health Board did not discuss with her that it had completed Mr X’s Do Not Attempt Cardiopulmonary Resuscitation Order (DNACPR) form; the Health Board failed to identify and take appropriate action when Mr X’s spleen had enlarged; and Mr X’s fluid intake and output was not closely monitored.

The Ombudsman found that Mr X received appropriate treatment to address sepsis. Whilst Mr X's spleen enlarged quickly prior to his death, the investigation found that he was receiving appropriate antibiotics and the Health Board could not have done any more. The Ombudsman also concluded that Mr X's fluid intake and output were closely monitored each day and appropriate decisions were made regarding fluid therapy.

The Ombudsman did, however, find that the Health Board did not discuss with Mr and Mrs X that it had completed Mr X's DNACPR form. This was not in accordance with national guidance. This complaint was therefore upheld.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mrs X; and
- b) remind relevant staff of their obligations under national guidance.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number 201607754 - Report issued in March 2018

In 2009, Mr X was diagnosed with central serous retinopathy (a visual impairment that affects the central area of the retina/macula due to fluid collecting beneath it) of his right eye and he was treated by photodynamic therapy ("PDT" – laser light). Mr X said that on 21 September 2015, he was administered excessive applications of PDT that resulted in permanent loss of vision to his right eye by burning. Mr X also complained that he could not get a response to the emergency out of hours service for eye patients on 24 October.

The Ombudsman found that Mr X's PDT had been on 16 October and that this procedure could not cause burning to his right eye. On 25 October 2016, Mr X's vision was noted to have improved, therefore, he could not have suffered permanent loss of vision. In relation to Mr X's consent procedure for PDT, the Ombudsman found that there was no separate clinical note and he could not be certain how much risk was explained to Mr X. The Ombudsman upheld the complaint to this limited extent only. The Ombudsman found that the out of hours service has a pre-recorded message that tells patients what to do and he did not uphold this aspect of the complaint.

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

- a) apologise to Mr X that the risk whilst obtaining consent was not also recorded in the clinical notes; and
- b) to remind staff that when advising patients about the risks of proposed treatments, the discussion should be recorded in the patient's clinical notes.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201700475 - Report issued in March 2018

In 1997, Mr Y was diagnosed with Von Hippel Lindau Disease ("VHL" – a progressive and rare familial disorder associated with reduced life expectancy and tumours). Mrs X complained that neither she nor her late son Mr Y, were informed that a May 2012 MRI brain scan showed shadows and he did not have another MRI scan within six months as recommended. On 5 January 2013, Mr Y died, the cause of death being cerebral oedema, cerebellar cyst and VHL syndrome. Mrs X also complained about the Health Board's investigation of her complaint.

The Ombudsman found that Mrs X and Mr Y should have been informed of the May 2012 scan result. He also found that Mr Y's presenting symptoms of earache and vertigo on 13 December were not symptoms of haemangioblastoma (a type of brain tumour associated with VHL) and there was no reason to expedite a scan. The Ombudsman found that Mr Y should have been informed of the intended management plan and a request for a further scan was not made because of a clerical error. In view of Cardiff and Vale University Health Board's ("the Health Board") previous apology and changes it had made to prevent a repetition, the Ombudsman made no recommendations. The Ombudsman also found that the Health Board's investigation had been thorough and timely.

Abertawe Bro Morgannwg University Health Board– Clinical treatment in hospital

Case Number 201700604 - Report issued in March 2018

Mr A complained about his father Mr B's management and care during his inpatient dementia assessment at Coed Cefn Hospital ("the Hospital"). Concerns included Mr B's indwelling catheter care, the effect of medication on him and his care not being caring, dignified or responsible. Finally, Mr A was dissatisfied with Abertawe Bro Morgannwg University Health Board's ("the Health Board") handling of his complaint. The Ombudsman's investigation identified additional clinical failings to that of the Health Board. He found inadequacies in the Hospital's management of Mr B's falls including a lack of medication review after falls. He felt communication with the family around medication could be improved and more done in the way of non-drug alternatives to manage non-cognitive behaviour that challenges (such as agitation and restlessness etc). The Health Board acknowledged shortcomings in the way it had dealt with Mr A's complaint and proposed a payment of £250 in recognition of this. The Ombudsman in reaching his findings took into account the steps the Health Board was taking and continued to take to address failings at the Hospital.

The Ombudsman upheld aspects of Mr A's complaint relating to clinical shortcomings and complaint handling and his recommendations included the Health Board:

- a) apologising
- b) making a payment of £250 for poor complaint handling;
- c) and taking steps to improve falls management, communication with families and documentation around non-drug interventions/activities.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number: 201702952 – Report issued in March 2018

Mr B complained that Cwm Taf University Health Board ("the Health Board") failed to appropriately treat, manage and investigate his father's hip pain and then inappropriately discharged him from hospital in December 2016. Mr B also complained that the Health Board had failed to communicate with him about his father's care, particularly in relation to his discharge and deterioration.

The Ombudsman found that there were shortcomings in the Health Board's standards of record keeping, and that Mr B's father was not formally reviewed, as is good practice, prior to his discharge. Whilst the care plan would likely not have changed, Mr B's father could have received a better care and pain management plan.

The Ombudsman recommended that the Health Board should apologise to Mr B, and offer him £300 (in place of his father). He also recommended that the Health Board should remind staff of the importance of ensuring patients are formally reviewed by a senior team member before they are discharged, and undertake quality audits of standards of clinical record keeping, and communication between departments, and take appropriate action to address any shortcomings identified.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number: 201607812 - Report issued in March 2018

Mrs X complained about the care provided to her late husband, Mr X, for his liver disease while an inpatient from 1 November to 25 November 2016. Mrs X specifically complained that Aneurin Bevan University Health Board ("the Health Board") failed to tell her about the severity of Mr X's condition following an ultrasound scan and failed to tell her about the seriousness and poor prognosis of Mr X's condition. Mrs X complained that the Health Board failed to provide Mr X with pain relief, and that Mr X was inappropriately discharged in November 2016 with no follow up.

The investigation found that Mr X had mental capacity to make his own decisions about his care and treatment and as such any communication about his care would have been directly with Mr X and the

clinicians. Mr X agreed to the plan of care for his cirrhosis and ascites. The Health Board acknowledged it failed to communicate with Mrs X and it had apologised to her and acknowledged its lack of communication in its initial complaint response. The investigation found that Mr X received appropriate pain relief for the procedures performed and when he requested it. Mr X's discharge was found to be appropriate and whilst a follow up appointment was requested for him on discharge, ultimately an appointment was not arranged. Whilst the reason for this remains unclear it had contributed to a delay in Mr X's second hospital admission but ultimately, the delay had no clinical impact on Mr X's condition. However, the period leading up to Mr X's second admission was clearly a stressful time for Mrs X which could have been avoided with better follow up care, and to that limited extent this issue was upheld.

Cardiff and Vale University Health Board Health - Clinical treatment in hospital

Case Number: 201700813 - Report issued in March 2018

Mrs X complained about Cardiff and Vale University Health Board's ("the Health Board") management of her eye condition following an urgent referral by her Optician in October 2015. In particular, Mrs X was concerned that, following her initial consultation, there was a delay in providing a follow up appointment/treatment. As she was concerned about the impact of the delay on her condition, she eventually sought private treatment.

The Ombudsman found a number of shortcomings in Mrs X's care and as a result of these, he concluded that Mrs X did not receive a reasonable or timely service. He found that the additional time Mrs X waited to be seen caused her anxiety and distress which led to her seeking private treatment. Had Mrs X been seen earlier, and a decision had been made for surgical intervention, she was more likely to have had a better outcome. The Ombudsman upheld her complaint and made a number of recommendations to the Health Board, including an apology to Mrs X and a redress payment of £1,500.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number: 201605599 – Report issued in March 2018

Mr A complained that his wife, Mrs A, should have been referred for a maxillofacial review, following her attendance at Morriston Hospital's Accident and Emergency Department ("the ED"). Mr A also complained that his complaint was not responded to in a timely and reasonable fashion. Additionally, Mr A complained that responses to his complaint had been contradictory and confusing and the Health Board had not set out a clear rationale that, after referring Mrs A for dental implant treatment, reversing its decision to fund her treatment, even though Mrs A's clinical situation had not changed.

The investigation found that that it would not have been standard practice for Mrs A to have been referred from the ED for a maxillofacial review. In relation to the second aspect of Mr A's complaint, the Health Board had responded in a timely and reasonable manner alongside ongoing correspondence to establish the best way forward for Mrs A's clinical treatment.

The investigation also found that the Health Board had given contradictory and confusing responses to Mr and Mrs A about the referral process from the ED and also found that clear terms of reference should have been agreed in relation to an external review of Mrs A's case. The Ombudsman recommended that the Health Board provide a written apology to Mr and Mrs A and advise relevant staff of the failings identified.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number: 201700928 – Report issued in March 2018

Mrs B complained about the manner in which the Health Board managed her husband's care following his admission to the Princess of Wales Hospital ("the Hospital") following a heart attack. Mrs B was concerned that there was a delay in Mr B being transferred to a specialist cardiac unit because of an episode of loose stools which led staff to commence infection control measures. Mrs B said that she had explained to staff that the likely reason for the loose stools was Mr B's prescribed medications. Mr B sadly died of a heart

attack at the Hospital a few days after his admission. Mrs B was also concerned that initially the Health Board did not explain the events that took place following Mr B's heart attack in hospital sufficiently.

The Ombudsman found that, whilst there had been no pressing clinical need for Mr B to be transferred, there was no documented risk assessment of the impact of delaying the transfer and no evidence of an explanation having been provided to Mr B's family for the delay. The Ombudsman also found that it was appropriate for the Health Board to implement infection control measures, despite Mrs B having suggested the cause to have been Mr B's medication. The Health Board acknowledged shortcomings in its communication with Mrs B about the sequence of events when Mr B suffered his heart attack in hospital.

The Ombudsman upheld the complaints involving failures to undertake an appropriate risk assessment, failing to communicate adequately with Mr B's family about the reasons for the delayed transfer and for the inaccurate explanations provided about the events at the time of Mr B's death.

The Ombudsman recommended that the Health Board clarify its wider infection control guidelines and to consider including a requirement for clinicians to undertake a risk assessment, if a delay for urgent care is being considered for infection control reasons.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201604945 - Report issued in March 2018

Miss X complained that the Health Board failed to provide her late mother, Mrs Y, with an adequate standard of care during her stay in Prince Philip Hospital ("the Hospital") in the period leading up to her sad death in 2014. Miss X said that Mrs Y was allowed to dehydrate and suffered acute renal failure as a result. She complained, among other things, that Mrs Y's pneumonia, diabetes and medications were mismanaged. Miss X was aggrieved that the Health Board did not respond properly in light of Mrs Y's dementia. Miss X also complained about what she perceived to be the inadequate investigation of her complaint by the Health Board.

The investigation found that the Health Board had failed to ensure that Mrs Y's fluid intake was appropriately supplemented for a number of days. This complaint was upheld. The Health Board agreed to apologise to Miss X for that failing and the distress it had caused.

The investigation also found shortcomings in how Mrs Y's diabetes had been managed (which had been reasonably addressed by the Health Board following its investigation) and how clinicians had responded to Mrs Y's cognitive impairment. These two complaints were partially upheld. The other complaints investigated were not upheld.

Not upheld

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201607099 – Report issued in January 2018

Ms X's Solicitor complained on her behalf that the standard of care and treatment provided to her by the Health Board had been unreasonable. The Solicitor considered that there had been an unreasonable failure to ensure that the entire placenta was removed during a caesarean section procedure undertaken at Prince Charles Hospital ("the Hospital") and that failure resulted in Ms X requiring further surgery.

The investigation found that the standard of care and treatment provided to Ms X had been reasonable. The later finding of retained products of conception after the caesarean section had been completed did not indicate that the checks undertaken during and immediately after that procedure were not performed with reasonable diligence. The complaint was, therefore, not upheld.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201607401 – Report issued in January 2018

Mrs P complained to the Ombudsman that, over a number of years Betsi Cadwaladr University Health Board ("the Health Board") had failed to investigate and manage gastric difficulties she was experiencing. She was particularly concerned that Health Board staff had failed to offer her a surgical procedure to address her symptoms which she eventually funded privately and that the Health Board had failed to undertake appropriate tests.

The Ombudsman found that the Health Board had conducted the appropriate investigations and that it had managed Mrs P's care appropriately. He considered that the decision by Mrs P's surgeons not to offer surgery was reasonable, based on their view that Mrs P's co existing medical conditions posed too high a surgical risk and that the risk posed by surgery did not outweigh the chances of a successful clinical outcome. Accordingly, the Ombudsman did not uphold the complaint.

Welsh Ambulance Services NHS Trust

Case Number 201700695 – Report issued in January 2018

Mr Y complained about the Welsh Ambulance Services NHS Trust ("WAST") who attended his late mother, Mrs X, in the early hours of Saturday 18 June 2016 after she had fallen. Mr Y complained that the ambulance crew failed to take Mrs X to hospital and failed to diagnose a fractured cheekbone.

The investigation found that Mrs X's care and management, including the decision not to convey her to hospital was reasonable, appropriate and made with Mrs X's best interests in mind. Further, the decision made was based on Mrs X's presenting condition, her assessed clinical status and symptoms at that time in conjunction with Mrs X's other clinical conditions. Accordingly, Mr Y's complaint was not upheld.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201607462 – Report issued in January 2018

Mr X complained that between June 2014 and February 2016 Betsi Cadwaladr University Health Board ("the Health Board") failed to appropriately respond to his son's suicidal feelings and failed to diagnose post-traumatic stress disorder ("PTSD"). Mr X also complained about inappropriate referrals in response to a diagnosis of PTSD and said there were missed opportunities to support his son and address his symptoms.

The Ombudsman acknowledged that revisiting events may have caused upset to Mr X. The investigation found that the Health Board's actions were in accordance with accepted practice utilising mental health and substance misuse assessments, care planning and risk assessment. The investigation also found that although there was not a clear diagnosis of PTSD, Mr X's son was nonetheless treated for PTSD and an appropriate service and care pathway. The Ombudsman did not uphold the complaint.

Welsh Ambulance Services NHS Trust and Betsi Cadwaladr University Health Board – Ambulance services

Case Number 201606125 & 201607502 – Report issued in January 2018

Miss X complained about the care and treatment provided to her late father, Mr Y, by the Welsh Ambulance Services NHS Trust ("WAST") and Welsh Ambulance Services NHS Trust ("the Health Board"). She complained that the ambulance crew who attended to Mr Y after he had suffered a heart attack made inadequate efforts to save his life, that there was an unreasonable delay before a defibrillator was used on Mr Y and resuscitation attempts and admission to Ysbyty Glan Clwyd were unreasonably stopped. Miss X also complained that at a local resolution meeting with Health Board staff she was erroneously informed there was no heart rhythm at any time and there was just a flat line for over 30 minutes, but when she asked to see a copy of the ECG (an electrocardiogram shows the electrical activity and rhythm of the heart) she could see clearly that there was ventricular fibrillation rhythm (a rhythm which was suitable for shocking with a defibrillator to try to restore a normal heartbeat).

The investigation found that reasonable efforts had been made by WAST staff to save Mr Y's life, that there had been no unreasonable delay before the first defibrillator shock was delivered to Mr Y and that the decision to discontinue resuscitation attempts had been reasonable, in the circumstances, and in Mr Y's best interests. Given the information available, it was unlikely that Miss X was told that there had been no heart rhythm at any time for over 30 minutes as that would have meant that Mr Y was not in a shockable state. However, he had been in a shockable state or shocks with a defibrillator would not have been delivered. The complaints were therefore not upheld.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201607823 & 201607820 – Report issued in February 2018

Mr A complained to the Ombudsman that following a road traffic Emergency Department staff at Wrexham Maelor Hospital failed to identify a spinal injury he had sustained. He complained that it was only following investigations at a specialist centre in England 18 months later, that the injury was discovered. He also complained that his GP (whose practice is managed by Betsi Cadwaladr University Health Board ("the Health Board")) failed to act on a referral letter from the specialist centre requesting a referral to the Health Board's orthopaedic service.

The Ombudsman found that staff at the Emergency Department followed correct procedures and that a scan taken just after the accident did not show any evidence of an acute injury. The Ombudsman also found that the referral letter from the specialist centre to the GP was not an instruction to the GP to make a referral but advice that should a spinal input be required it would be for the GP to make the referral. The Ombudsman considered that it was appropriate for the GP to await input from, Mr A before making such a referral. The Ombudsman did not uphold either aspect of the complaint.

Betsi Cadwaladr University Health Board - clinical treatment in hospital

Case Number 201607456 – Report issued in February 2018

Miss X complained about the standard of care provided to her mother, Mrs Y, by Betsi Cadwaladr University Health Board's mental health services in April 2015. Miss X was concerned about Mrs Y's mental capacity to make decisions and about the appropriateness of her discharge.

The Ombudsman found that Mrs Y had capacity to make decisions. He also found that the decision to discharge was reasonable. He did not uphold the complaints.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201607270 - Report issued in March 2018

Ms X complained about the poor standard of care provided to her in respect of injuries she sustained to her hand and wrist after a horse riding accident. She was aggrieved that the treatment for her injuries had been incorrect and ineffective.

The investigation found that the standard of care and treatment provided to Ms X had been reasonable. Whilst it was acknowledged that Ms X's injury had not resolved during the period under consideration, that was not found to be because of inadequate care on the part of the trauma and orthopaedic surgeons involved in the management of her injury. The complaint was therefore not upheld.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201703333 - Report issued in March 2018

Mr B complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to provide treatment to his wife, Mrs C, within the 14-day window, he had been advised was necessary in her case. The Health Board offered treatment at the first available appointment which would have been a few weeks after Mrs C was first seen. Within a few days Mrs C sought treatment at a clinic in another health board's area and was treated immediately.

The Ombudsman did not uphold the complaint. He found that there was no guidance specific to Mrs C's condition and whilst it was acknowledged that the treatment Mrs C needed becomes less effective if not administered within a few weeks, as Mrs C sought treatment elsewhere, it is not possible to know if the treatment would have been effective, if given on the date planned by the Health Board.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201700991 - Report issued in March 2018

Mr and Mrs X complained about the scoliosis (where the spine twists and curves to the side) correction procedure their teenage daughter, Miss X, underwent at the University Hospital of Wales on 20 October 2016. Mr and Mrs X said that screws were misplaced during this procedure and they were not given a medical update by the surgeon.

The Ombudsman found that the consent form for the procedure, documented misplaced screws as a risk; they are a recognised complication and not surgical error. Mrs X said that even had she been made aware of the risks, she would have consented to the procedure. The Ombudsman did not uphold this aspect of the complaint. The Ombudsman found that Miss X had many medical reviews after the procedure and was appropriately reviewed when the mal-positioned screw was identified. The Ombudsman did not uphold this aspect of the complaint.

A GP Practice in the area of Cwm Taf University Health Board – Clinical treatment outside hospital

Case Number 201701210 - Report issued in March 2018

Mrs X complained about a GP Surgery's actions in relation to her late son's alcohol detoxification treatment, in particular, whether it was appropriate for the Surgery to refer him for community alcohol detox treatment, and whether it was appropriate for a GP not to have prescribed Mr X diazepam at a consultation.

The Ombudsman found that it was entirely appropriate for Mr X to have been referred for a community detox, and that there was no indication that he should have been admitted to hospital for treatment. The community detox appeared to have been carried out appropriately, and Mr X stopped drinking alcohol. In relation to the actions of the GP, the Ombudsman found that it was reasonable for him not to have prescribed diazepam on that occasion as Mr X had admitted obtaining diazepam from unauthorised sources, had taken an overdose of ibuprofen tablets, and was showing no signs of significant mental illness or suicidal thoughts. The Ombudsman did not uphold the complaints.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number 201701393 - Report issued in March 2018

Mr C complained about the care and treatment he received from Hywel Dda University Health Board ("the Health Board"). In particular he was unhappy that between July and August 2016 he was not given a diagnosis or treatment when he complained of poor vision.

The investigation found that Mr C was assessed appropriately and it was entirely reasonable for an MRI scan to be undertaken to rule out potential causes of Mr C's eye condition. The investigation also found that a firm diagnosis and treatment would likely have been given to Mr C had he not self-discharged on two occasions.

The Ombudsman did not uphold the complaint.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201604945 - Report issued in March 2018

Miss X complained that the Health Board failed to provide her late mother, Mrs Y, with an adequate standard of care during her stay in Prince Philip Hospital ("the Hospital") in the period leading up to her sad death in 2014. Miss X said that Mrs Y was allowed to dehydrate and suffered acute renal failure as a result. She complained, among other things, that Mrs Y's pneumonia, diabetes and medications were mismanaged. Miss X was aggrieved that the Health Board did not respond properly in light of Mrs Y's dementia. Miss X also complained about what she perceived to be the inadequate investigation of her complaint by the Health Board.

The investigation found that the Health Board had failed to ensure that Mrs Y's fluid intake was appropriately supplemented for a number of days. This complaint was upheld. The Health Board agreed to apologise to Miss X for that failing and the distress it had caused.

The investigation also found shortcomings in how Mrs Y's diabetes had been managed (which had been reasonably addressed by the Health Board following its investigation) and how clinicians had responded to Mrs Y's cognitive impairment. These two complaints were partially upheld. The other complaints investigated were not upheld.

Early resolution and voluntary settlements

Hywel Dda University Health Board – Continuing Care

Case Number 201703618 – Report issued in January 2018

Mrs A complained on behalf of her mother Mrs B who has dementia and resides in a care home. Mrs A complained about concerns relating to the assessments of Mrs B's eligibility for Continuing Health Care ("CHC"), the Social Worker's involvement in the assessment processes and that the outcome of a mental health assessment had not been disclosed.

It was agreed that Welsh Ambulance Services NHS Trust ("the Health Board") would reconsider the complaint under the NHS formal complaints process and provide a written response to the complainant within 6 weeks of the date of this decision.

It was agreed that the response would include:

- a) The involvement of the Social Worker in the assessment processes, an explanation as to their status and confirmation that the Health Board had shared the concern with the Social Worker and the agency directly responsible for her role.
- b) Provide the outcome of the section 2 mental health assessment, or alternatively provide an explanation as to why it has not been disclosed.
- c) Provide a response to the procedural concerns raised with regard to the decision making process relating to Mrs B's eligibility for CHC funding.

Cardiff and Vale University Health Board – Continuing Care

Case Number 201705777 – Report issued in January 2018

Following a decision to reject the late Mrs A's application for retrospective NHS Continuing Healthcare ("NHSCHC"), Mrs X complaining on behalf of the late Mrs A said that the decision of the Independent Review Panel ("IRP") was unreasonable, clinically unsound and based on inappropriate considerations. Specifically, that, contrary to paragraph 3.61 Continuing NHS Healthcare Framework, the IRP considered whether Mrs A's needs were being met by the staff at the care home in which she lived and the NHS Funded Nursing Care ("FNC") that she was receiving rather than whether a primary health need existed.

Cardiff and Vale University Health Board agreed to reissue the decision letter providing a full and robust explanation of the reasons why it was felt that a primary health need did not exist, while ensuring that any references to FNC were excluded from the decision.

Betsi Cadwaladr University Health Board – Continuing Care Case Number 201705391 – Report issued in January 2018

Miss A complained to the Ombudsman about her referrals for appointments with Cardiff and Vale University Health Board's ("the Health Board") Community Mental Health Team (CMHT). Miss A said that she had three referrals for a medication review with the CMHT but was seen on the first appointment by a trainee nurse who was unhelpful. She also said that after she cancelled her second and third appointments the CMHT discharged her for non-attendance, and she was referred for counselling. Miss A said she felt that an appointment with a nurse wasn't appropriate, and that a counsellor isn't sufficiently trained to review medications and she would need to see a psychiatrist.

Although the Ombudsman declined to investigate Miss A's complaint, he recognised that the Health Board had already accepted in its formal complaint response that it had caused Miss A distress and upset, for which it apologised. However, it appeared that the Health Board had not addressed Miss A's concerns about her appointment with a trainee nurse and whether a counsellor is sufficiently trained to review medications. 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 Miss A with an explanation of who is able and qualified to carry out a medication review and why.
- (b) to provide Miss A with clarification on whether her third appointment with the CMHT was due to her GP's continued concern or her conversation with a CMHT Manager.

Aneurin Bevan University Health Board - Other Case Number 201705056 – Report issued in January 2018

Mrs B & Mrs C complained about what had happened to their late elderly father, Mr A, whilst he was a patient at one of Aneurin Bevan University Health Board's ("the Health Board") hospitals. Mr A, a devout Sikh, suffered from dementia and when the family visited him one day they discovered that a Health Care Worker ("HCW") had trimmed his beard and facial hair. The HCW said she had done so with Mr A's consent, and for his comfort when eating. Mrs B & Mrs C said that they, the wider family, and Mr A, were distraught to discover this, and that it was an act of religious violation. Mr A had throughout his life never cut his beard (according to strict Sikh religious observance). No one had approached them about Mr A's views or religious needs. Mr A passed away some ten days later. Mrs B & Mrs C felt that his decline had been contributed to by the event. They were unhappy about the Health Board's actions since, being unconvinced there had been any wider learning.

Whilst not for the Ombudsman to make definitive findings about human rights issues, and alleged infringement of them, he considers complaints with these issues in mind and will comment on them, if appropriate. On considering the complaint documentation, the Ombudsman noted that given his beliefs, diagnosis of dementia, and distress at the outcome, it was certain that Mr A was not able to properly consent to the trimming of his facial hair. That act engaged his rights under Articles 3, 8 and 9 of the ECHR. As a public authority, the Health Board should have regard to, and not act incompatibly with, these ECHR rights. What had happened to Mr A should not have happened. The Ombudsman felt that there was an opportunity to resolve the complaint, whilst ensuring wider learning from the events. Therefore, he made the following comprehensive recommendations, which the Health Board agreed to implement:

- (a) To further apologise in writing to Mrs B & Mrs C for the events that had caused them such distress (within one month)

- (b) To provide an action plan by way of update to Mrs B & Mrs C on steps taken to date, and on the Ombudsman's recommendations (within two months)
- (c) To develop resource information, and a checklist, for all HCWs and nursing staff likely to have daily/frequent interaction with a patient on key inter faith points – covering the main cultures/faiths known from the Health Board area's demographic profile (within three months). To provide a pilot inter faith learning session for the ward where Mr A was a patient, rolling this out to raise awareness, and to include such information within the induction training of all new HCWs and nursing staff.
- (d) To ensure such key cultural information is visible and clearly recorded in the patient's care plan (and to provide evidence of a reminder to staff about recording - within two months)
- (e) To review its Equality & Diversity training plan and include the listed matters below within the wider Equality & Diversity training delivered for all staff to undertake within ABUHB's ongoing programme (seeking specialist advice as necessary - review and provide details within six months):
 - (i) Cultural and religious observance
 - (ii) Critical importance of family communication about such matters
 - (iii) Human Rights and the ECHR
- (f) To implement a process, as best practice (within two months), whereby sufficient information is gathered about the specific needs of all dementia patients on their admission (especially those observing different cultures or religions) to include the following actions (save on acute admissions where this may not be immediately practicable):
 - (i) Providing the "This is me" document on admission to the family when a patient with a diagnosis of dementia is admitted (unless the family indicates one has already been completed and can be provided)
 - (ii) Recording that the document has been given to the family for completion
 - (iii) Providing, as necessary, assistance to a family member with completing the document
 - (iv) Ward staff caring for the patient are given a verbal summary of any specific needs/requirements, once known, and as set out in "This is me", and a written record made of any specific requirements in the patient's care plan
 - (v) A copy of the "This is me" document is placed and retained in the patient's clinical records (for immediate reference if there are future / multiple admissions.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201705540 – Report issued in January 2018

Mrs A complained to the Ombudsman about the standard of care provided to her mother whilst she was an inpatient in hospital. Mrs A said that her mother had sustained injuries because of a fall during the night and that a staff member had failed to provide her with assistance. She also said that photographs were taken of her mother's injuries and she was concerned that the fall had occurred the day before she passed away.

Although the Ombudsman declined to investigate Mrs A's complaint, he recognised that Abertawe Bro Morgannwg University Health Board's ("the Health Board") investigation had identified that there were no written records to confirm what had occurred during the night in question or to corroborate the verbal accounts given by staff members during the course of its investigation. Because of this, he contacted the Health Board and it agreed to do the following within one month:

- (a) to provide a full written apology to Mrs A for the shortcomings in record keeping that had contributed to the uncertainty caused about the standard of care afforded to her late mother.
- (b) to offer Mrs A a redress payment of £250, in recognition of the uncertainty and distress this has caused.
- (c) to remind all staff of the importance of good record keeping ensuring that all staff are aware of their obligation to keep clear and accurate contemporaneous records relevant to their practice, and to maintain records in such a way that they are both retrievable and usable
- (d) to take steps to ensure that all staff are aware of the correct procedure to follow if they find a patient whose safety may have been compromised.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital

Case Number 201704348 – Report issued in January 2018

Mrs D complained that she was unhappy with the work and content of a report that was completed by a member of staff at the Health Board's Child and Adolescent Mental Health Services ("CAMHS") team.

She also complained regarding other issues which included the delay by Abertawe Bro Morgannwg University Health Board ("the Health Board") in dealing with her complaint.

The Ombudsman found that there was little further that could be achieved for the complainant after considering the Health Board's response to her.

There was one element of her complaint, however, that was assessed as needing further action by the Board. The Ombudsman contacted the Health Board and it agreed to;

a) Append the complainant's response to content written within a Mental Health report completed by it after her son's recent assessment.

It has agreed to do this within 20 working days of the date of this letter.

The Ombudsman considers that this action resolves the outstanding issue included in the complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number: 201705748 – Report issued in January 2018

Ms X complained about the way Betsi Cadwaladr University Health Board ("the Health Board") responded when she reported an incident regarding a junior doctor. Ms X reported that when she underwent an intimate examination, the junior doctor mistakenly examined the wrong area. The Health Board had accepted that the service provided was not of an acceptable standard and that there was a breach in its duty of care, however it had concluded that there was no qualifying liability in relation to Mrs X's concern.

The Ombudsman found that there had initially been an apparent failure on the part of the Health Board to appreciate the gravity of the incident and the impact it had on Ms X. Ms X felt violated and traumatised; she lost faith in the NHS and its doctors and felt that the complaint response had "brushed [the incident] under the carpet".

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

- a) Apologise that the investigation so far has been unsatisfactory, and offer a meeting with Associate Director of Quality Assurance, the Associate Medical Director for Quality and Safety, and an independent mediator to be appointed by the Health Board
- b) Fully reconsider the matter of qualifying liability and redress including psychological intervention/support and financial redress
- c) Write to Ms X to confirm the outcome of the meeting and follow-up on any actions agreed

Abertawe Bro Morgannwg University Health Board

Case Number 201703412 – Report issued in February 2018

Miss X complained to the Ombudsman about the manner in which her complaint was handled by Abertawe Bro Morgannwg University Health Board ("The Health Board")

The Ombudsman found that the Health Board had not handled Miss X's complaint in a timely manner and that the complaint response was incomplete and dismissive of her concerns. The Health Board agreed to the following within two months:

- a) Provide Miss X with a written apology and a £250 redress payment to reflect the delays she experienced as well as for the unhelpful and dismissive wording within the complaint response letter.
- b) Review the complaint handling process between the clinician and the complaints department.

Cwm Taf University Health Board - clinical treatment in hospital

Case Number 201702282 – Report issued in February 2018

Mr X complained about the treatment his daughter, Y, received at a young person's mental health unit ("the Unit") run by Cwm Taf University Health Board ("the Health Board") at the Princess of Wales Hospital. The Ombudsman was unable to consider Mr X's complaint about Y's treatment without her express consent.

As an alternative resolution, the Health Board agreed to hold a meeting between Mr X, the Unit's Clinical Director and the Assistant Director of Operations for CAMHS and Mental Health, to discuss his general concerns and to learn of improvements made to the hospital facility about which he complained.

The Ombudsman considered the action agreed to be reasonable to address the complaint.

Betsi Cadwaladr University Health Board - clinical treatment in hospital

Case Number 201706871

Mr H complained to Betsi Cadwaladr University Health Board ("the Health Board") about its care of his late father. The Health Board provided Mr H with a written response to his complaint. Mr H wrote again to the Health Board asking a series of questions arising from its response.

Although the Health Board offered Mr H a meeting to discuss the outstanding issues he did not feel able to attend a meeting and requested a written response, which the Health Board refused to provide. He complained to the Ombudsman about this refusal. The Health Board agreed to respond in writing to Mr H's questions, in settlement of his complaint.

A GP Surgery in the area of Abertawe Bro Morgannwg University Health Board – Appointments/admissions/discharge and transfer procedures

Case Number 201706471 – Report issued in February 2018

Mr X complained that the Surgery issued a warning for failing to attend an appointment for an Asthma review. Mr X said that the letter was following a review which was undertaken for various other ailments and was told by the Prescribing Clerk "it was not necessary" to attend the Asthma review as it was included.

The Ombudsman noted that Mr X's formal letter of complaint to the Surgery, dated 21 October 2017, had not been responded to. He contacted the Surgery which advised that it never received Mr X's complaint. It therefore agreed to undertake the following actions in settlement of this complaint:

1. To respond to Mr X's complaint no later than 2 March.
2. To look into its incoming post system and satisfy itself that it is appropriate.

A GP Surgery in the area of Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital

Case Number 201706048 – Report issued in February 2018

Ms A complained to the Ombudsman about an incident relating to her appointment at a GP surgery, during which she was told the Police would be called. Ms A said that as a result she was made to feel like a criminal and uncared for as a patient. Ms A also said she was now too afraid to contact or attend the surgery, and that it had failed to resolve how she should access GP services.

Although the Ombudsman declined to investigate Ms A's complaint, he recognised that the Practice had accepted in its formal complaint response that Ms A felt her treatment was unfair, for which it apologised. However, Ms A's concerns about ongoing attendance and police intervention had not been addressed. Because of this, he contacted the Practice and it agreed to do the following within one month of the date of this decision.

- (a) To provide Ms A with a written explanation about how she could access medical services at the Practice, to allay her anxieties about attendance and police intervention.

Cwm Taf University Health Board- Appointments/admissions/discharge and transfer procedures

Case Number 201706180 – Report issued in February 2018

Miss A complained to the Ombudsman about the treatment her grandfather, Mr B, received from the Health Board whilst an in-patient at Prince Charles hospital. Miss A said that the process of her grandfather's discharge from the hospital was unsafe, that there were communication errors with the family and between the hospital and social services, and that there was no discharge meeting with the family despite their express request. Miss A said that her mother, Mr B's daughter, who was herself unwell, was left to transport Mr B home without any support, despite the fact that he was unable to weight bear. Miss A said that Mr B lost a lot of weight and developed pressure sores whilst in hospital.

Although the Ombudsman declined to investigate Miss A's complaint, he identified certain issues with the formal complaints response provided by Abertawe Bro Morgannwg University Health Board ("the Health Board"). Because of this, he contacted the Health Board and it agreed to do the following:

- (a) to provide Miss A with a clear outcome of a review of the Occupational Therapy notes
- (b) to investigate Miss A's complaint that Mr B had experienced skin breakdown, and lost over a stone in weight whilst an in-patient with the hospital
- (c) to provide the Ombudsman with supporting evidence to demonstrate that Mr B's experience had been shared with the relevant teams, as previously indicated in its formal complaints response.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201706795 – Report issued in February 2018

Mrs A's complaint related to the care and treatment she received during and subsequent to her admission to hospital in June 2016. Mrs A said there was a delay in providing her with a follow up surgical appointment and confirming her diagnosis of secondary liver cancer. She also complained that there was a delay in responding to her complaint and a failure to acknowledge correspondence.

The Ombudsman declined to investigate Mrs A's complaint, mainly because the issues were out of time and he did not consider that any shortcomings in the complaints handling were sufficiently serious. However, he contacted Abertawe Bro Morgannwg University Health Board and it agreed to respond to the alleged delay in confirming Mrs A's more recent diagnosis of secondary liver cancer as this had not been addressed.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201703365 - Report issued in March 2018

Ms A's complaint centred on her management and care when she underwent an angiogram at Glan Clwyd Hospital on 4 January 2017. Ms A said that she had complained of pain, when two unsuccessful attempts were made to insert the catheter through an artery located in her groin. The catheter was subsequently inserted by accessing an artery in her wrist ("the radial artery"). Some days after the procedure, Ms A was admitted as an inpatient having developed a deep vein thrombosis (blood clot) in her leg as a result of the procedure.

The Ombudsman started an investigation but was unable to complete his investigation as the Health Board was unable to find pertinent medical records.

In recognition of the injustice caused to Ms A as a result, Betsi Cadwaladr University Health Board ("the Health Board") agreed to the following:

- a) apologise to Ms A for the loss of her medical records
- b) make a payment to her of £500 and review how effectively it tracked its medical records
- c) review how it carried out its coronary procedures
- d) consider using the radial artery as the preferred access route; and
- e) take reasonable steps to try to locate Ms A's missing records.

Powys Teaching Health Board and Betsi Cadwaladr University Health Board – Continuing Care

Case Numbers 201702490 & 201703074 - Report issued in March 2018

Ms K complained, via a firm of solicitors, that there were unacceptable delays by Betsi Cadwaladr University Health Board ("the Health Boards") in the handling of her retrospective claim for continuing healthcare funding on behalf of her late mother. The claim had originally been submitted in 2010, but had still not been determined by the time Ms K complained to the Ombudsman in July 2017.

The Health Boards accepted that there had been administrative failings in this case which had caused excessive delay in the handling of the claim. They agreed that:

- The Phase 1 part of the claim would be dealt with according to the procedure that existed at the time.
- Powys would endeavour to progress the review of both Phase 1 and Phase 2 periods of the claim to the point of negotiation within three months.

The Ombudsman discontinued his investigation on the basis that Ms K agreed the actions proposed by the Health Boards and the failings which had occurred in this case were unlikely to happen again as the process for handling retrospective claims had changed since 2010.

**Aneurin Bevan University Health Board – Appointments, admissions, discharges and transfer procedures
Case Number 201706318 - Report issued in March 2018**

Miss X complained that her daughter was inappropriately discharged from Aneurin Bevan University Health Board's ("the Health Board") eating disorder service without forewarning or explanation. Miss X said that the decision caused distress to her daughter and undermined her trust in the service and its professionals. The Ombudsman considered the complaint and noted that the Health Board had sought to explain to Miss X, in response to her complaint, the reason for the decision.

It also recognised that there had been some communication failings and made recommendations for service improvement.

Although the Ombudsman considered that investigation of these matters was not merited he noted that the Health Board had not appropriately apologised to Miss X and her daughter for the distress caused by the communication failings identified.

The Health Board therefore agreed to provide a written apology to Miss X within one month.

Complaint Handling

Early resolution and voluntary settlements

Cardiff and Vale University Health Board

Case Number 201704643 – Report issued in January 2018

Mrs X has complained about Cardiff and Vale University Health Board's ("the Health Board") handling of her complaint regarding a Dental Practice in the Health Board's area.

In response to the Ombudsman's investigation the Health Board said it would apologise to Mrs X for the incorrect use of the Putting Things Right Regulations when addressing her complaint. It also offered to pay Mrs X £250 to reflect the time and trouble caused to her in pursuing her complaint with the Ombudsman.

The Ombudsman considered this to be a reasonable settlement of the complaint and therefore discontinued his investigation.

Dyfed-Powys Police and Crime Commissioner – Various Other

Case Number 201704744 – Report issued in January 2018

Mr T has a disability that affects his ability to communicate. He complained that the Dyfed-Powys Police and Crime Commissioner ("the Commissioner") failed to consider and respond to his complaint about a Chief Constable, failed to make reasonable adjustment for his communication needs, and then failed to respond to his complaint about the Commissioner's service.

The Ombudsman found that the Commissioner failed to acknowledge or respond to Mr T's request for a reasonable adjustment, and he should have considered how to communicate effectively with Mr T, and whether any reasonable adjustment was appropriate. As a result of this failing, the Commissioner was unable to address the substance of Mr T's complaint about the Chief Constable.

The Commissioner agreed to undertake the following actions, in settlement of the complaint.

Within six weeks of the date of this decision, the Commissioner would:

1. Apologise for failing to respond to Mr T's requests for a reasonable adjustment, which resulted in a failure to address his complaint about the Chief Constable;
2. Take action to identify the substance of Mr T's complaint against the CC, and provide a response to it. Where further information is required, the Commissioner should explain precisely what information is required from Mr T, and why; and
3. Work with Mr T to identify what reasonable adjustments might be made to ensure effective communication, and provide him with a clear explanation of what (if any) reasonable adjustments will be made to facilitate communication.

Within three months of the date of this decision, the Commissioner would:

4. Ensure that all public facing staff within the Commissioner's office have awareness training in respect of how they deal with individuals with additional needs, including providing appropriate reasonable adjustments, and that key learning points are shared with other staff and relevant departments as appropriate.

Betsi Cadwaladr University Health Board – Health

Case Number 201705291 – Report issued in January 2018

Ms X complained that at the time of submitting her complaint to the Ombudsman, in November 2017, she had not received a response from Betsi Cadwaladr University Health Board ("the Health Board") to a complaint she submitted in July 2016.

Upon receiving this complaint, the Ombudsman contacted the Health Board and it agreed to undertake the following in settlement of the complaint:

1. Write to Ms X apologising for the continued delay and the handling of the complaint, no later than 17 January 2018.
2. Provide a financial redress payment of £500 in recognition of its delays, no later than 17 January 2018.
3. Expedite the complaint and issue its response letter, no later than 1 February 2018.

Cwm Taf University Health Board - Health

Case Number 201705785 – Report issued in January 2018

Mr B complained about the handling of his complaint by Cwm Taf University Health Board (“the Health Board”).

The Health Board investigated Mr B’s complaint about an incident that occurred in a Practice in its area when Mr B was being administered a vaccination.

The Ombudsman found that the Health Board had investigated and responded to Mr B’s concerns. The Health Board provided information to the Ombudsman regarding the changes it had made to the vaccination process and informed that the Practice staff had undertaken further training.

However, at no point had the Health Board apologised to Mr B for the distress caused by the incident. Therefore, the Health Board agreed the following in settlement of the complaint:

- a) Apologise to Mr B for the distress caused by the incident.

The Health Board provided a copy of its letter dated 4 January 2018, evidencing that it had completed the above agreed action.

Hywel Dda University Health Board - Health

Case Number 201705555 – Report issued in January 2018

Mr B complained that Hywel Dda University Health Board (“the Health Board”) had failed to respond to his complaint to it within a reasonable time.

The Ombudsman considered his complaint and contacted the Board. It agreed to

- (a) Write a letter to the complainant offering £300 in recognition of the time and trouble taken by him in pursuing his complaint.

This will be completed within 20 working days of the date of the decision letter in this case.

Newport City Council – Children’s Social Services

Case Number 201706191 – Report issued in January 2018

An advocate complained on behalf of Ms B that Newport City Council (“the Council”) had failed to provide its Stage 2 Social Services response to the complaint she had raised in August 2017.

The advocate’s complaint was submitted to the Ombudsman on 22 December 2017. The Council subsequently provided its complaint response on 3 January 2018. The Ombudsman considered that the Council, in responding to the complaint, had failed to apologise to Ms B for the significant delay in issuing its response.

Therefore, in settlement of the complaint, the Council agreed to complete the following actions by 28 February 2018:

- a) Apologise to Ms B for the delay in responding to the complaint
- b) Explain the reasons for the delay to Ms B
- c) Offer a payment of £100 to Ms B for the distress caused by the delay and the time and trouble in raising the complaint with the Ombudsman.

Cwm Taf University Health Board - Health

Case Number 201706236 – Report issued in January 2018

Ms X complained about the delay in Cwm Taf University Health Board (“the Health Board”) responding to her complaint about the care provided to her father at Prince Charles Hospital.

Ms X made her complaint to the Health Board in June 2017. The Ombudsman found that the Health Board had provided updates to Ms X during the course of its investigation, but that there had been a delay in the response being issued.

In settlement of the complaint, the Health Board agreed to complete the following actions by 7 March 2018:

- a) Issue the complaint response
- b) Apologise for the delay in responding to the complaint
- c) Offer a payment of £75 for the time and trouble in raising the complaint with the Ombudsman.

Cardiff Community Housing Association Ltd

Case Number 201706329 – Report issued in February 2018

Mr B complained about Cardiff Community Housing Association Ltd (“the Housing Association”) response to his complaints about alleged antisocial behaviour by a neighbour. Whilst the matter was ongoing, the Housing Association had not responded to Mr B’s formal complaint.

After being contacted by the Ombudsman, the Housing Association agreed to provide a formal response to Mr B, and the complaint was closed on that basis.

A GP practice in the area of Betsi Cadwaladr University Health Board – Clinical treatment outside hospital

Case Number 201706130 – Report issued in February 2018

Mrs A complained to the Ombudsman about the standard of care provided to her father by a GP Practice, currently managed by the Health Board, in the twelve to fifteen months before his death. Mrs A also complained about the Health Board’s complaint handling process and that its findings did not fully address her questions about her father’s care and sudden death.

Although the Ombudsman declined to investigate Mrs A’s complaint, he recognised that the Health Board’s Level 1 Root Cause Analysis had identified learning points in its action plan which had not been evidenced. He therefore contacted the Health Board and it agreed to provide evidence within one month that the following actions have been completed:

- (a) that a GP had attended an ECG refresher course
- (b) that the Area Team/Practice Manager had implemented a robust Communication Policy
- (c) that all GP’s had included reflections and learning from this case in their next GP appraisal
- (d) that a GP had attended a GP update course in order to address personal development needs
- (e) that information had been disseminated within the Health Board of the lessons learned as a result of Level 1 concerns investigations.

Cardiff Council - Education

Case Number 201707182 - Report issued in March 2018

Mr A complained that Cardiff Council (“the Council”) had failed to respond to his complaint that he had experienced additional and unplanned transport costs following the Council’s decision to relocate his daughter to another education facility for certain lessons two days of the week.

Mr A’s complaint had previously been referred to the Council by the Ombudsman’s office in October 2017. Despite subsequent enquiries being made to the Council by the Ombudsman, the Council failed to respond to Mr A’s complaint.

Therefore, in settlement of Mr A's complaint, the Council agreed to complete the following actions:

- a) Provide its response to Mr A's complaint by 31 March 2018
- b) Provide any reimbursement payments to Mr A by 16 April 2018
- c) Apologise for the significant and unacceptable delay in responding to Mr A's complaint by 16 April 2018
- d) Offer a payment of £500 by 16 April 2018 in recognition of the unacceptable delay in responding to Mr A's complaint, and for the time and trouble in Mr A making a further complaint to the Ombudsman's office.

Aneurin Bevan University Health Board – Health

Case Number 201706383 - Report issued in March 2018

Ms X complained that during a meeting between her and representatives of the Health Board held in May 2017, it was agreed by Aneurin Bevan University Health Board ("the Health Board") that it would review its original final response to her complaint and issue an amended response as soon as possible. However, the Health Board failed to follow up on this agreed action and she was still awaiting its revised response to her complaint. Her Community Health Council advocate chased the Health Board for the response on several occasions yet it remained outstanding.

Upon assessing the information available, the Ombudsman was disappointed to note that the Health Board failed to follow up on the actions it had previously agreed with Ms X. The Health Board therefore agreed to undertake the following in settlement of her complaint:

- a) A commitment to expediting resolution of the issues raised and to issue the proposed revised formal response as soon as possible following the redress panel scheduled to meet on the or 22 March 2018.
- b) A copy of the holding letter and apology which was to be sent to Ms X from the complaints hub to be sent to the Ombudsman by 27 February 2018 (at the time of writing the summary, this has been received).
- c) A payment of £125 to be made to Ms X (by 20 March 2018) by way of redress for the prolonged wait she has endured in the Health Board's handling of her complaint

Cwm Taf University Health Board - Health

Case Number 201706435 - Report issued in March 2018

Mrs A complained that the Health Board acted unreasonably when it made a Child Protection referral to social services in relation to her two children. Mrs A said that the Health Board had ample opportunity to address the concerns contained within the referral with her prior to making the referral, but it had not done so. Mrs A was concerned that there was poor communication within the Health Board, and also between the Health Board and Mrs A and her family.

Although the Ombudsman declined to investigate Mrs A's complaint, he was concerned that there had been a delay in addressing potential Child Protection concerns with the family.

Because of this he contacted the Health Board who agreed to do the following:

- (a) To provide a formal, written apology to the family for the distress that they suffered as a result of the delay in addressing potential Child Protection concerns with them;
- (b) To offer the family a payment of £125 for the time and trouble they have been caused in bringing their complaint;
- (c) To provide supporting evidence to demonstrate that all staff within the team have been reminded of the correct procedures to follow in cases where there are potential Child Protection concerns;
- (d) To respond to outstanding matters of complaint after the return of a key member of staff from sickness absence.

Betsi Cadwaladr University Health Board - Health

Case Number: 201706441 - Report issued in March 2018

Mr A complained about delays by the Health Board in providing treatment for his symptoms of pain and phobia, prior to being able to undergo hip replacement surgery. Mr A also complained about the Health Board's handling of his complaint.

The Ombudsman found a delay in Mr A's care pathway between February 2014 and July 2015. The Ombudsman also found poor communication and delays by the Health Board's when handling Mr A's complaint and that matters had not been satisfactorily concluded in accordance with the regulatory requirements.

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

- a) Apologise to Mr A for the poor handling of his complaint.
- b) Provide Mr A with a redress payment of £250 in recognition of consequential delays and frustration caused.
- c) Consider the issue of qualifying liability relating to delays in Mr A's care pathway.
- d) Carry out a review of current arrangements for managing correspondence on closed complaints to ensure not only that it is acknowledged and actioned promptly but also that any outstanding work is visible in the event of unplanned leave.
- e) Share the Ombudsman's provisional views on the complaint with Mr A's GP to reflect on their involvement in his care.

City and County of Swansea

Case Number 201706930 - Report issued in March 2018

Ms A complained about the action taken by the Council in consequence of a decision issued by the Ombudsman on 21 December 2017.

The Ombudsman found that an apology letter issued by the Council to Ms A implied that he was satisfied with an aspect of her complaint that had not been investigated.

On receipt of Ms A's complaint, the Ombudsman contacted the Council and it agreed to amend and re-issue the apology letter to ensure that there was no misunderstanding about the extent of the Ombudsman's findings.

Hywel Dda University Health Board – Health

Case Number: 201704085 – Report issued in March 2018

Ms X complained about the management of her complaint by Hywel Dda University Health Board ("the Health Board"). In particular, she said that the Health Board failed to keep her informed of the progress made during its investigation and took an unreasonable time to respond to her concerns.

During the investigation, the Health Board reviewed its handling of Ms X's complaint and recognised that it took an unreasonable time to respond. Consequently, the Health Board agreed to undertake the following actions, in order to settle the complaint:

- Provide Ms X with a written apology for its failure to handle her complaint in a timely manner; and
- Provide Ms X with a sum of £250 in recognition of the frustration caused by its failure to handle her complaint in a timely manner.

The Ombudsman considered that the action the Health Board said it will take is reasonable and accordingly, the matter is regarded as settled.

Education

Upheld

Ceredigion County Council –Special Educational Needs

Case Number 201603867 - Report issued in January 2018

Mr A complained that the Ceredigion County Council (“the Council”) acting a Local Education Authority (“LEA”) had failed to deliver the provision set out in his son, X’s, Statement of Special Education Needs (“Statement”). X had been sent home months previously from the residential school that he had attended for many years as the school said it could no longer meet his needs. Attempts to find an alternative residential school had failed and limited progress made to provide some interim education for X locally; in part due to a lack of agreement with Mr A but also owing to X’s complex needs. He required mental health support (included within his Statement) and it was clear that this was needed to ease him back into any formal curriculum provision, a point the LEA later accepted. X reached his 19th birthday (so, in law, bringing his Statement to an end) before any arrangements for a new school placement could be made.

The investigation found that the LEA had initially made reasonable attempts to try to meet some interim provision for X, given its limited ability to meet his complex needs locally. However, knowing his need for support, it had not done all it could to assist in a timely mental health referral. That was vital to enable X to engage and ease him back into formal lessons – key if he was to return to any formal/school education setting. There was a lack of communication with other Council officers who had knowledge of X’s difficulties before he was sent home from the school, and so a delay on the part of the LEA in convening a proper planning meeting with relevant professionals. That might have facilitated an earlier mental health referral, and his ability to undertake some education, albeit it was unlikely X could have returned to a residential school before his 19th birthday.

The Council/LEA agreed to implement the following recommendations within one month:

- a) Apologise to X (through Mr A) for the delay in convening the planning meeting resulting in the delayed referral and consequential impact this had for re-engaging in education and
- b) Offer redress of £2000 to Mr A for the benefit of X and his future aspirations

Early resolution and voluntary settlement

Cardiff Council – Special Educational Needs

Case Number 201705190 – Report issued in January 2018

Mr and Mrs X complained that Cardiff Council (“the Council”), in its role as the Local Education Authority, failed to complete an annual review of their son’s Statement of Education Needs (“SEN”) in line with the Special Educational Needs Code of Practice for Wales 2002 (“the Code”) in 2016 and 2017.

The Council had accepted that the Code had not been fully adhered to. An apology was provided and assurances given that staff would receive additional training to ensure that the process for undertaking annual reviews would be fully followed in line with the Code in future cases.

An apology was also provided for the delay in issuing a proposed amended SEN. The Council assured Mr and Mrs X that the SEN would be amended as soon as their son was fully integrated into his educational setting. However, Mr and Mrs X were concerned about the vagueness of the timescale provided.

The Ombudsman recognised that the Council had already taken some action to resolve matters. Although he declined to investigate, he contacted the Council to see if it would be willing to take some further to fully address the complaint. It agreed to undertake the following in settlement of the complaint:

- (a) within one month, to update Mr and Mrs X's sons SEN to ensure it reflect his current circumstances;
- (b) Within two months, to confirm the content of the additional training to be provided to all staff members and the timescales for its deliverance;
- (c) Within two months, to offer to Mr and Mrs X a redress payment in the amount of £250, in recognition of the distress and anxiety caused to them due to the failure to adhere to the Code and for their time and trouble in bringing their complaint to the Ombudsman.

Environment and environmental health

Ceredigion County Council – Drainage/Sewers/Culverts

Case Number 201700132 – Report issued in January 2018

Mr X complained that Ceredigion County Council ("the Council") failed to act once an enforcement notice had expired on neighbouring land. Mr X also complained that the Council failed to update him or respond to his queries in accordance with policy, procedure or good practice and failed to manage his complaint in accordance with its complaint procedure. Mr X said that his property remained a health hazard as neighbouring contaminated water continued to seep onto his land.

The investigation found that the Council had not acted contrary to its policy in deciding not to take further action on its enforcement notice and it was a decision it was entitled to take. In respect of updating Mr X, the Ombudsman found that the Council could have been clearer with him about its role in the process, but was encouraged by its acknowledgement of any delay. The investigation found no policy to suggest that any other form of action was required by the Council.

In respect of complaint management, the investigation found that there had been a delay in responding to Mr X's complaint but noted that the Council had visited him to attempt to resolve the concern. The Council also apologised for the delay which was reasonable. The Ombudsman did not uphold these complaints.

Bridgend County Borough Council – Refuse collection, recycling and waste disposal

Case Number: 201706368 - Report issued in March 2018

Mr A complained that the Council acted unreasonably because its contractor failed to collect his waste and recycling on a number of occasions between April and September 2017. Mr A also complained about the Council's handling of his complaints.

Although the Ombudsman declined to investigate Mr A's complaint, he was concerned that there had been some issues with collection of Mr A's waste and recycling, and that there had also been shortcomings in its complaints handling.

Because of this, he contacted the Council who agreed to do the following:

- (a) Provide a meaningful apology to Mr A for the missed waste and recycling collections he experienced between April and September 2017, and for the way his complaints were handled and responded to;
- (b) Offer Mr A the sum of £50 in recognition of the time and trouble he spent in making his complaint.

Merthyr Tydfil County Borough Council – Pollution and pollution control

Case Number 201706788 - Report issued in March 2018

Mr X complained that Merthyr Tydfil County Borough Council ("the Council") has failed to take enforcement action against a neighbouring log burner which is causing smoke issues to his family.

The Ombudsman found that there had been significant correspondence between the Council and Mr X regarding the log burner, dating back to 2015. The Council's most recent visit to consider matters occurred in September 2017.

Therefore, as a further six months have passed since the last visit, the Council agreed to contact Mr X in order to ascertain whether the situation regarding the log burner had changed since its last visit, and whether a nuisance now exists.

The Council contacted Mr X on 15 March 2018 in order to obtain further information to enable it to consider whether re-opening Mr X's case was now necessary.

Housing

Upheld

Wrexham County Borough Council – Applications/allocations/transfers and exchanges

Case Number 201702971 – Report issued in January 2018

Ms X complained about the way in which Wrexham County Borough Council ("the Council") handled her housing application. Ms X's ill health meant her privately rented property had become unsuitable, and she had accumulated significant arrears of rent because of her reduced income.

The Ombudsman found there had been a delay of some six-seven weeks in entering Ms X's name on the waiting list, although he could not conclude that this would have affected the outcome. However, there was a lengthy delay in the Council making a request for assistance to an English council to which Ms X wished to move (partly caused by a misunderstanding of the law), which meant that Ms X lost the opportunity of being considered for housing in the English council area during that time. He upheld the complaint to that extent only. The Ombudsman recommended the Council apologise to Ms X, make a payment of £400 to her in recognition of the distress and uncertainty caused by the failings he identified, and remind officers of the relevant legal provisions.

Bron Afon Community Housing Ltd – Neighbour disputes/anti-social behaviour

Case Number 201607511 – Report issued in January 2018

Mr X complained that Bron Afon Community Housing Ltd ("the Housing Association") had, over a number of years, failed to adequately address his complaints of anti-social behaviour, relating to the behaviour of the tenant living next door to him and members of her family/friends/visitors to her property.

Mr X's complaints were intermittent, and he had, on occasions, been content with the actions the Housing Association had taken. The Ombudsman found that the Housing Association's actions between 2013 and 2015 had been broadly reasonable; although the tenant should have been warned that she might be in breach of her tenancy agreement, there was no way of knowing if this might have had a more lasting effect on the situation.

However, when Mr X continued to make complaints during the first half of 2016, the Housing Association delayed taking action while it attempted to meet Mr X to discuss the situation (which had not been possible at least in part because of Mr X's ill health). The Ombudsman found that the Housing Association should

have taken more prompt action during this period, and the Ombudsman upheld the complaint to that extent only. He recommended that the Housing Association apologise to Mr X for the delays, reflect on the report and thereafter develop an action plan to address any issues identified.

Charter Housing Association – Repairs and maintenance

Case Number 201604415 - Report issued in March 2018

Ms A complained to the Ombudsman about a failure by Charter Housing Association (“the Housing Association”) to address damp issues within her home over a number of years. She was also aggrieved that the Housing Association had taken an excessive length of time to construct a porch outside her flat and that this had caused her significant hardship over the winter whilst she was undergoing and recovering from chemotherapy. She was also unhappy about the size of her kitchen, arguing that it did not comply with housing standards.

The Ombudsman found that the Housing Association had failed to take steps to address damp problems in Ms A’s home over a four-year period and that it had taken an unreasonable period of time to construct the porch causing Ms A unacceptable disturbance. He also found that the Housing Association had failed to provide Ms A with an air purifier to remove mould spores from the air in her property whilst she underwent and recovered from chemotherapy. He upheld these aspects of her complaint. Whilst the Ombudsman acknowledged that it appeared that some aspects of Ms A’s kitchen did not meet housing standards, the Housing Association had taken reasonable action to try to address these issues as far as was possible. He did not uphold this aspect of the complaint.

In relation to the failure to deal with the damp and to the delays in constructing the porch and for failing to provide an air purifier, the Ombudsman recommended the Housing Association should:

- a) Pay a total redress of £5,450
- b) Take further action to address some of the shortcomings highlighted by this case.

Early resolution and voluntary settlements

Clwyd Alyn Housing Association Ltd – Repairs and maintenance

Case Number 201705417 – Report issued in January 2018

Ms X complained that Clwyd Alyn Housing Association (“the Association”) had failed, on a number of occasions, to appropriately repair/prepare her fences before painting them, following recommendations by the Ombudsman in March 2016. She also raised the concern that she had received a letter from the Association dated 31 October 2017 apologising for a delay in its investigations but then received a complaint response dated 12 October in an envelope date stamped 2 November.

In March 2016, the Ombudsman found that the Association had changed its policy so that it no longer painted fencing but stained the external face only. It was also found that there was no minuted evidence of its change in practice. Therefore, the Association agreed to undertake a number of actions, including the painting of Ms X’s fence and formally approving a policy document that properly reflected its practice.

Ms X was not satisfied with how the Association out the agreed action and, therefore, brought her complaint back to the Ombudsman in November 2017.

After consideration of the recent complaint, the Ombudsman found no evidence that the Association acted contrary to written policy and procedure in the circumstances, and was satisfied that it had carried out the agreed actions. However, he found the discrepancy in the dating of letters to be unacceptable and so requested that the Association explain how this arose.

The Association agreed to (i) apologise to Ms X and (ii) provide an explanation for this error. A letter was sent to Ms X dated 16 January 2018.

Flintshire County Council - Estate management and environment/common areas/hedges and fences etc Case Number 201705996 – Report issued in January 2018

Mr B complained about the time taken by Flintshire County Council ("the Council") in responding to his application to its Assisted Gardening Scheme ("the Scheme"). Mr B was also dissatisfied with the decision reached by the Council regarding his application.

The Ombudsman found that the Council had taken four months to respond to Mr B's application, but it had apologised for the inconvenience caused by the delay and offered a reasonable explanation for its decision.

The Council considered that Mr B was not eligible for the Scheme as his garden area was subject to its 'Open Space' maintenance contract.

Therefore, in settlement of Mr B's complaint, the Council agreed to complete the following action by 12 February 2018:

- a) A Housing Officer is to visit Mr B to clarify which areas will be cut by the Council's 'Open Space' maintenance contractors.

Wrexham County Borough Council – Repairs and maintenance

Case Number 201705960 – Report issued in February 2018

Miss A complained that Wrexham County Borough Council ("the Council") had categorised repairs to her property, namely the re-plastering of two small bedrooms, as "non-urgent" and had advised that the repairs would be completed within 12 months. Miss A had provided the Council with a letter from her health visitor explaining the medical impact of the current state of repair of the rooms on her family. Although the Ombudsman declined to investigate Miss A's complaint, he was concerned that there were discrepancies between the Council's policies in relation to the set timescales for completion of such repairs. He was also concerned that the medical evidence provided had not been given sufficient weight in assessing the priority level of the repairs. Finally, he was concerned that the Council no longer provided a single "Tenants Handbook" document to its tenants, but that there were references to such a document on its website and in tenancy agreements. Because of this, he contacted the Council who agreed to do the following:

- (a) to confirm that the re-plastering repairs had been completed by 30 March 2018;
- (b) to address the discrepancy in its policy documents;
- (c) to address the references to the "Tenants Handbook" on the Council's website and in the tenancy agreements.

Charter Housing Association – Repairs and maintenance

Case Number 201707079 - Report issued in March 2018

Mr A raised a number of concerns about the service provided by his landlord relating to maintenance requests, improvements and physical adaptations.

On receipt of the complaint, the Ombudsman contacted Charter Housing Association ("the Housing Association"). It investigated the complaint further and identified several areas where it felt that its service had fallen short. In settlement of the complaint the Housing Association volunteered to undertake the following actions:

- a) Arrange a meeting with Mr A to discuss his outstanding concerns and to apologise to him in person for the failings identified.
- b) Make a redress payment of £200 for the unacceptable delay in carrying out physical adaptations to his home.
- c) Make a further redress payment of £100 for shortcomings in its communication with Mr A.
- d) Reimburse Mr A's costs for materials purchased before permission to carry out improvement work to his driveway was withdrawn.

Trivallis Housing Association – Repairs and maintenance

Case Number: 201700645/201701231 – Report issued in March 2018

Mrs A and her daughter complained that Trivallis Housing Association (“the Housing Association”) had failed to rectify serious disrepair and structural defects at their adjoining properties. They also complained that the properties were infested with rats. Mrs A said that her daughter was living in the property with her disabled partner and daughter and that the poor living condition was having an adverse effect on their health.

In responding to the Ombudsman’s investigation, the Housing Association acknowledged there had been shortcomings in its handling of Mrs A and her daughter’s case and this extended to record keeping. They set out the factors that had contributed to the delay which included a number of independent structural surveyors’ reports being commissioned as Mrs A was unhappy with the level of works identified.

The Ombudsman after careful consideration of the facts felt that there was scope in this case for a settlement. The Housing Association also confirmed that after providing assurances that Mrs A and her daughter could return to the properties, they had now agreed to move into alternative accommodation while the work was carried out. The Housing Association set out the measures it had put in place to manage the schedule of works identified. In addition, the Housing Association agreed that:

- Following the works, it will provide confirmation that the properties have no structural defects and that necessary repairs have been carried out to the roof. That necessary redecorations were undertaken at both properties. It will ensure that pest control checks are carried out prior to both Mrs A and her daughter returning to their properties.
- It would make the necessary compensation payments to Mrs A and her daughter as set out in its decant policy.
- It would pay a redress figure of £500 each to Mrs A and her daughter in recognition of any delays and the resulting stress, disruption and inconvenience caused by the works.

Planning and building control

Upheld

Blaenau Gwent County Borough Council – Handling of planning application

Case Number 201606268 – Report issued in January 2018

Mr X’s complaints related to his plan to construct wind turbines on his land to generate electricity for the National Grid. He complained that he was unreasonably forced to relocate the position of a wind turbine by Blaenau Gwent County Borough Council’s (“the Council”) Rights of Way Officer. He also complained that the Council had unreasonably refused to discharge a planning condition relating to the requirement for surveys to be undertaken in respect of breeding and wintering birds. Mr X complained that there was an unreasonable delay, on the part of the Council, in stating its position with regard to valuing an easement for allowing a connection by cable to be made across its land.

The investigation found that the Rights of Way Officer was entitled to state his intention to object to the proposed siting of a turbine. It found that the Council had not unreasonably refused to discharge the planning condition in question. These complaints were not upheld. The investigation found that there had been an unreasonable delay on the part of the Council in stating its position with regard to the valuing of the easement in question. This complaint, therefore, was upheld.

The Council agreed to:

- a) apologise to the complainant for the delay in stating its position regarding the easement
- b) and to offer a payment of £375 as financial redress for the delay in progressing the matter.

Llanwinio Community Council – Rights of way and public footpaths

Case Number 201706444 - Report issued in March 2018

Mrs P complained that Llanwinio Community Council (“the Council”) had not responded appropriately to concerns raised about access to public rights of way in the locality. Mrs P said that the Council had failed to take action and treated her unreasonably since she submitted a report relating to the matter in 2016. The Ombudsman identified that although Mrs P had asked questions of the Council and demanded that action be taken her concerns had never been expressed as a formal complaint for consideration under an appropriate complaints procedure. Enquiries with the Council identified that it did not have a current Complaints Process.

The Ombudsman sought the Council’s agreement to:

- (a) Prepare and adopt a formal complaints procedure within two months.
- (b) Investigate and provide a detailed response to the complaints made in accordance with the relevant (to be adopted) procedure.

Powys County Council – Handling of planning application (other)

Case Number 201706477 - Report issued in March 2018

Mr A complained that Powys County Council (“the Council”) had made an incorrect decision regarding an application for a Certificate of Lawful Use. This was in relation to an old corrugated sheet building and hard standing near his home. He also complained that the Council had not responded to his complaint in a timely manner.

For jurisdictional reasons, the Ombudsman was unable to investigate the decision made by the Council. He did, however, consider the element of his complaint regarding the complaint handling and found that there had been some delays.

The Ombudsman contacted the Council which agreed to:

- (a) Write to Mr A apologising for the delays in its complaint handling
- (b) Offer £50 payment in recognition of time and trouble taken by Mr B in pursuing his complaint

This will be completed within 20 working days of the date of this letter by 12 April 2018.

Roads and Transport

Early resolution and voluntary settlements

Wrexham County Borough Council - Other

Case Number 201705889 – Report issued in January 2018

Mr B complained that Wrexham County Borough Council (“the Council”) had failed to erect a road sign which it had told him had been ordered several months previously.

In settlement of Mr B’s complaint, the Council agreed to:

- a) Erect the road sign
- b) Apologise for the delay in erecting the road sign
- c) Provide an explanation for the delay.

The Council confirmed to the Ombudsman that the road sign has now been erected and agreed to complete actions b) and c) within two weeks of the Ombudsman’s decision.

Cardiff Council – Street lighting

Case Number 201705972 – Report issued in February 2018

Mr X complained that Cardiff Council (“the Council”) had failed to adequately respond to his complaints about street lighting which was left on throughout the day; parking enforcement issues; or the cost to the Council of hosting the Champions League Final 2017. Mr X also complained that the Council’s complaints procedure was “not fit for purpose”.

The Ombudsman found that the Council had provided Mr X with a guideline of June 2017 for the street lights to be replaced, but that this had not taken place. Therefore, the Council agreed to complete the following in settlement of this element of the complaint:

- a) Expedite the replacement of the street lights and complete the works by 31 March 2018

The Ombudsman considered that the Council had appropriately responded to Mr X’s concerns about obstructive parking in the area in which he lived.

Whilst the Ombudsman cannot consider matters regarding the cost to the Council to host an event, he found that the Council had informed Mr X that the costings would be available to him by November 2017, but had failed to provide a follow up response. In settlement of this element of the complaint, the Council agreed to complete the following:

- b) Provide Mr X with the final costings for hosting the Champions League Final, if they are now available, by 19 March 2018.

The Ombudsman found that there were significant delays in the Council responding to Mr X’s complaints. The Council had acknowledged and apologised to Mr X for the delays. Whilst the delays in responding to Mr X do not necessarily indicate that the Council’s complaints procedure is not fit for purpose, the Ombudsman reminded the Council of the importance of adhering to the timescales of its own complaints procedure, and to provide meaningful updates to complainants where this is not possible.

Cardiff Council - Parking

Case Number 201706217 – Report issued in February 2018

Miss H complained that Cardiff Council ("the Council") had offered no provision for parking in the area in which she lives, and that it refused to exercise discretion in considering her request for a parking permit. The Ombudsman considered that the explanation provided by the Council not to exercise discretion in considering Miss H's parking permit application was reasonable at that time.

However, following enquiries made by the Ombudsman, the Council subsequently confirmed that Miss H lives in a block of flats which was granted planning permission which stated that resident parking would be available.

Therefore, the Council agreed to complete the following actions by 5 March 2018 in settlement of Miss H's complaint:

- a) Award a parking permit to Miss H in accordance with the relevant parking permit policy
- b) Apologise to Miss H for any confusion and/or inconvenience caused
- c) Consider comparable actions in response to any other individuals with similar circumstances.

Flintshire County Council – Traffic regulation and management

Case Number 201707342 - Report issued in March 2018

Mr B complained that Flintshire County Council ("the Council") had failed to respond to his complaint regarding large vehicles using a narrow lane that runs alongside his property.

Mr B had raised a Stage 1 complaint with the Council in November 2017 and, despite receiving a holding letter, was still to receive a response from the Council when making his complaint to the Ombudsman in February 2018.

In settlement of the complaint, the Council agreed to complete the following actions:

- a) Issue its Stage 1 response to Mr B's complaint by 31 March 2018
- b) Apologise for the significant delay in issuing its response by 31 March 2018
- c) Offer a payment of £65 to Mr B by 12 April 2018 in recognition of the significant delay in responding to his complaint.

Social services – adult

Upheld

Isle of Anglesey County Council - Other

Case Number 201607733 – Report issued in January 2018

Mr X complained to the Ombudsman about the way in which the Isle of Anglesey Council (“the Council”) assessed his wife’s, Mrs X’s, financial contribution towards her care home charges and its review of his challenge to that assessment. Mr X also complained that, when his wife started to receive a financial contribution from the Council towards her care home charges, he was not given the choice of a suitable equivalent care home in the area that did not require the payment of ‘top up fees’.

The Ombudsman did not find any maladministration in the way the Council had carried out the financial assessment, however he found that the Council had not considered Mr X’s challenge to the assessment in line with updated legislation. This element of his complaint was partially upheld. The Ombudsman also found that Mrs X should have been given the option to consider a move to an alternative home without ‘top up fees’ when she started to receive a financial contribution from the Council towards her care home charges. This element of Mr X’s complaint was upheld.

The Ombudsman recommended that the Council:

- a) apologise to Mr X
- b) provide him with a redress payment of £250 for his time and trouble in making a complaint
- c) make a redress payment of £1,096 to reflect the incorrect payment of the top up fees.
- d) consider creating an information leaflet to assist individuals with understanding the review request process and asked it to update its policy in relation to the shortcomings identified.

The Council agreed to the recommendations.

Newport City Council – Services for older people

Case Number 201607368 – Report issued in February 2018

Ms C complained that Newport City Council (“the Council”) failed to properly investigate her concerns that her grandmother, Mrs B, had been. The Ombudsman found that the Council had not undertaken a meaningful investigation of concerns raised about the possible neglect or abuse Mrs B may have suffered due to her level of vulnerability. He also found that the Council could have undertaken an earlier assessment of Mrs B’s capacity and made enquiries to establish whether Mrs B was a victim of financial abuse.

The Council agreed to apologise to Ms C and pay her £500 in recognition of the distress caused by failing to investigate her concerns thoroughly and the time and trouble taken in pursuing the complaint. It also agreed to undertake an audit of vulnerable adult referrals, review the content of the report with the staff involved and arrange training, if necessary. The Council also agreed to review its process for undertaking capacity assessments and ensure that the welfare of the vulnerable adult is put first.

Early resolution and voluntary settlements

Neath Port Talbot County Borough Council – Services for Older People

Case Number 201703251 – Report issued in January 2018

Mrs X and Mrs Y complained about:

- The refusal by Neath Port Talbot County Borough Council (“the Council”) to hold a case conference following the POVA investigation into their late mother’s care (following its previous indication that it would do so)

- The Council's response to the Stage 2 investigation report.

The Council agreed to hold a case conference, and to provide a further response to the Stage 2 report. The Ombudsman therefore discontinued the investigation.

Pembrokeshire County Council - Services for people with a disability

Case Number 201706296 – Report issued in March 2018

Mr A complained that Pembrokeshire County Council ("the Council") had failed to implement the recommendations of its Independent Investigation into a complaint made by Mr A on behalf of his daughter Miss B against its Social Services Department.

Although the Ombudsman declined to investigate Mr A's complaint, he was concerned that some recommendations had not been completed and that there had been a delay in implementing others.

Because of this, he contacted the Council who agreed to do the following:

- a) provide a meaningful apology to Mr A and his family
- b) re-send documents which had been sent to the family's solicitor at a time when the complainant did not believe the solicitor was instructed
- c) contact the family to ask whether they wished to have a meeting with the new social worker and new Service Manager to address any further issues, and if so, to arrange such a meeting.

Social services – children

Early resolution and voluntary settlements

Welsh Government - CAF/CASS Cymru

Case Number 201705911 – Report issued in February 2018

Miss R complained that CAF/CASS had failed to provide her with a copy of the appointed Guardian's report prior to the relevant hearing, as ordered by the Court. She also complained that she did not receive a full copy of the report until a number of months later, by which time it was too late to lodge an appeal.

The Ombudsman found that it is usual accepted procedure, where a Solicitor is instructed, for that person to undertake to file the report with the Court and ensure all parties receive copy. However, in this case that did not happen. Furthermore, once it was made aware that Miss R did not have a copy of the report, CAF/CASS was not proactive in ensuring a complete copy was provided to her.

CAF/CASS agreed to undertake the following actions, within four weeks of the Ombudsman's decision, in settlement of the complaint:

- Apologise that the usual process, whereby an instructed Solicitor would serve all parties with a copy of the Guardian's report, was not adhered to in this instance.
- Apologise that, once it was made aware Miss R had not received a copy of the report, it did not take timely or proactive action to provide a complete copy to her.

Various other

Flintshire County Council – Recruitment and appointment procedures

Case Number 201702001 – Report issued in January 2018

Mr and Mrs D complained, on behalf of their grandson, Mr E, that Flintshire County Council (“the Council”) withdrew a conditional offer of employment to Mr E on the basis of his medical condition. Mr and Mrs D maintained that the occupational health doctor (“the Doctor”) who assessed Mr E had little knowledge of his medical condition and that the Council had overestimated the scale of adjustments necessary to allow Mr E to fulfil the role. Mr and Mrs D also complained about the way Mr E was told about the decision, and the time the Council took to do so.

The Ombudsman found that the Doctor was appropriately qualified to provide an opinion on Mr E’s medical condition and that the Council was entitled to take account of his advice. The Council’s decision to withdraw the offer of employment was one it was entitled to take on the basis of the information it had. The Ombudsman did not uphold this part of the complaint. The Ombudsman also did not criticise the way Mr E was informed of the decision, but he noted that there was a delay in sending a letter confirming the decision, which was due to an administrative error. To the extent there was a delay in sending the confirmation letter, he upheld this part of the complaint. As the Council had already apologised, the Ombudsman did not make any further recommendations.

Early resolution and voluntary settlements

Cardiff Council – Poor/no communications

Case Number 201707061 – Report issued in February 2018

Mr B complained about the way Cardiff Council (“the Council”) handled its communications with him in relation to a number of concerns he had raised relating to planning, licencing, environmental services and waste management. After contacting his local Councillor, Mr B raised his concerns with the Council in January 2017 and advised that he wished to raise a formal complaint in March. Mr B said that the Council did not acknowledge, investigate, act on or respond to his concerns appropriately.

The Ombudsman found that the Council failed to coordinate its responses, which varied in terms of timeliness and whether they offered meaningful information, from each department. The Council also failed to ensure that Mr B was appropriately informed on the relevant complaints procedure, keep Mr B updated on any progress, or provide a satisfactory conclusion to his complaints.

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

- (a) Apologise for the complaint handling failures identified and offer £250 to Mr B for his time and trouble in pursuing the complaint
- (b) Clarify the complaint procedure which should consider Mr B’s complaints and take steps to ensure it is progressed appropriately
- (c) Ensure that a full update is provided to Mr B on any actions the Council has taken regarding his concerns over the last year, and where further action is required ensure that Mr B is updated promptly and regularly until the matters are concluded, which it should aim to do within three months
- (d) Remind all elected members of the Council’s complaint mechanisms, and their responsibility to signpost constituents to the Corporate Complaints Procedure when appropriate
- (e) Remind all C2C front-line staff of the importance of referring any complaint that is a repeat complaint and/or involves a number of different departments to the Corporate Complaints Department to ensure a response is appropriately coordinated
- (f) Take steps to ensure that all relevant staff, including frontline C2C staff and teams operating within shared partnerships, know what the arrangements are for complaints, and their role in carrying them out, and can clearly advise complainants appropriately