

The Ombudsman's Casebook

Issue 33 July 2018

News

Ombudsman Bill Financial Resolution Approved

The Financial Resolution in respect of the Public Services Ombudsman (Wales) Bill was approved by the National Assembly for Wales with Assembly Members voting 45-1 in favour.

The Bill now proceeds to Stage 2 where Committee will consider amendments.



PSOW Conducts Compliance Visit

In April, the Ombudsman visited Ysbyty Glan Clwyd to see what progress had been made following the publication of two high profile public interest reports.

The Ombudsman said he was pleased that his recommendations from reports were being used to improve services. A media report on the visit can be found [here](#).

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Health

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

Section 16

Hywel Dda University Health Board – Clinical treatment in hospital

Case number: 201607619 – Report issued in June 2019

Mrs A complained about the care and treatment that she and her late son, Baby C, received from Hywel Dda University Health Board ("the Health Board"). Specifically, Mrs A complained that there had been a failure to monitor Baby C's development during her pregnancy and labour, a failure to provide her with a birthing plan and a failure to respond to her concerns about unusual pains during labour. Mrs X also complained that there had been a delay in Baby C seeing a paediatrician, receiving treatment and a failure to conduct necessary tests after birth.

Mrs A complained that the Health Board had not only failed to adequately respond to her complaint, but it had failed to conduct a full investigation into the cause of Baby C's death which resulted in her being given different reasons for Baby C's death. Finally, Mrs A complained that Baby C's death was incorrectly registered as a "stillbirth".

The complaint was upheld, and it was recommended that the Health Board:

- a) Provides Mr and Mrs A with a meaningful apology for the failings identified in this report.
- b) Pays Mrs A the sum of £4500 in recognition of the distress, delay and uncertainty she experienced in this matter, the cost incurred for the private scan and the time and trouble in bringing her complaint to this office.
- c) Identifies the clinicians and midwives responsible for the care of Mrs A and Baby C and discusses the content of this report in their supervision sessions, sharing any lessons learned with colleagues within the department.
- d) Ensures compliance with the process for providing information to parents of babies that have been stillborn or neonatal death.
- e) Changes Baby C's status from "stillborn" to "neonatal death".

The Practice agreed to implement these recommendations.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number: 201700714 – Report issued in May 2018

Ms X complained about the care and treatment provided to her late brother, Mr Y, during two admissions to Prince Charles Hospital ("the Hospital") in April 2015. Ms X complained about whether it had been clinically appropriate to discharge Mr Y following his first admission. Ms X was also concerned about the care provided to Mr Y during his second hospital admission and whether any action could have been taken to prevent Mr Y's bowel from perforating and sepsis developing, from which Mr Y sadly did not recover.

The Ombudsman found that the decision to discharge Mr Y following his first admission was reasonable and did not uphold this element of the complaint. During Mr Y's second hospital admission, the Ombudsman found that there were a number of shortcomings in the care and treatment provided which fell well below reasonable standards. The response to Mr Y's deterioration was highly unsatisfactory and sepsis should

have been recognised and treated earlier. A severe complication of colitis (dilation of the colon) was not identified promptly which led to the perforation of Mr Y's colon and critical illness. This was a significant failing and clearly Mr Y should have undergone surgery sooner. The Ombudsman found that the delay significantly increased the likelihood of a poor outcome. The shortcomings in the identification and treatment of sepsis also increased the risk to Mr Y. Cwm Taf University Health Board ("the Health Board") agreed with the Ombudsman's finding that Mr Y should have undergone surgery sooner which would have increased the chance of a more positive outcome for Mr Y.

The Ombudsman upheld these complaints and recommended that the Health Board:

- a) Write a letter of apology to Ms X for the significant shortcomings in Mr Y's care.
- b) Provide financial redress of £4,500 to Ms X in respect of these shortcomings and the injustice caused to Mr Y in that he did not receive adequate treatment for the suffering he endured. This represents an injustice to Ms X and her family who will now have to live with the uncertainty of knowing that, had Mr Y received adequate treatment, it would have increased his chances of survival and in recognition of the real uncertainty which remains as to whether the outcome for Mr Y could have been different if Mr Y had undergone surgery sooner.
- c) Ensure that arrangements are in place for patients with severe colitis to be managed via a multidisciplinary approach with involvement and leadership by consultant gastroenterologists and consultant colorectal surgeons.
- d) Provide training for ward staff in communication with family and carers of vulnerable patients with a history of mental illness and of appropriate care pathways for such patients.
- e) Discuss the contents of this report with the Consultant Surgeon to emphasise the importance of providing clear and accurate information to complainants during Health Board investigations.
- f) Carry out an audit to ensure that the management of sepsis by medical staff is in line with national requirements and includes a protocol for escalation and clear care pathways.
- g) Carry out an audit to ensure that there is adequate consultant (physician and surgical) cover for gastroenterology patients at all times.

The Health Board agreed to implement these recommendations.

Upheld

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#)

[Case Number: 201702553 – Report issued in April 2018](#)

Mrs X complained about the care her late father, Mr Y, received at Morriston Hospital in January and February 2016. Sadly, Mr Y died on 3 February. Mrs X complained about staff communication with her, treatment for Mr Y's fractures, manual handling, pain relief, discharge arrangements and record-keeping in relation to a multi-disciplinary team meeting and the care provided during Mr Y's final hours.

The Ombudsman found some shortcomings in respect of recordkeeping but concluded that these did not result in any significant adverse outcome. He concluded that, overall, the clinical and nursing care provided to Mr Y was of an appropriate standard. Accordingly, he found that the complaints about the care Mr Y received should not be upheld.

However, the Ombudsman found Abertawe Bro Morgannwg University Health Board's ("the Health Board") handling of Mrs X's complaint to have been highly disorganised and delayed and its formal response inadequate. The Ombudsman concluded, therefore, that the complaint about complaint handling should

be upheld. The Ombudsman recommended that the Health Board should apologise to Mrs X and provide financial redress in the sum of £400 in recognition of the time and trouble to which she was put in pursuing this complaint and the additional distress that this caused following an unexpected bereavement.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case Number: 201700809 – Report issued in April 2018](#)

Miss A developed a Deep Vein Thrombosis (“DVT”) after hip replacement surgery. Miss A has Antiphospholipid Syndrome (“APS”), which can increase the risk of blood clots. Miss A was concerned that her risk of developing a DVT was not properly assessed, and that appropriate preventative measures were not taken to reduce the risk of her developing a DVT. She also complained about information she was given about physiotherapy and that there were delays in her being seen by a physiotherapist after she was discharged home.

The Ombudsman found that the clinicians treating Miss A had appropriately recognised the risk of Miss A developing a DVT, albeit it would have been good practice to have included a formal written DVT risk assessment in the records. The Ombudsman found that the course of preventative medication Miss A was given post-surgery was just about reasonable; however, it did not appear that she was provided with TED stockings. The Ombudsman partly upheld this part of the complaint.

There was no record of Miss A’s consultation with a hospital physiotherapist before discharge, and Miss A said that she was not given information about how often she should do the exercises she had been given. The Ombudsman upheld this part of the complaint. He did not uphold the part of the complaint about delays in seeing a community physiotherapist as Miss A was seen within the relevant timescales.

The Ombudsman recommended that Cwm Taf University Health Board (“the Health Board”) apologise to Miss A and also remind relevant staff about standards of record keeping and the communication of information about physiotherapy. He also recommended that the Health Board include a section for a formal DVT risk assessment in its surgical preoperative assessment documentation.

[Hywel Dda University Health Board – Clinical treatment in hospital](#)

[Case Number: 201701157 – Report issued in April 2018](#)

Mrs B complained that Ophthalmologists within Hywel Dda University Health Board (“the Health Board”) failed to adequately and promptly investigate a sudden loss of vision that she experienced in her left eye in January 2015. Mrs B complained that the cause of her loss of vision was misdiagnosed and, as a result, she was prescribed treatment that worsened her condition.

Mrs B also complained that:

- a) Ophthalmologists failed to carry out a surgical procedure to remove/disperse a blood clot in a timely manner. She was therefore obliged to have this procedure carried out privately at considerable expense.
- b) A Consultant Ophthalmologist was dismissive of her concerns and suggested that no further treatment of her left eye was possible or necessary, given that the vision in her right eye was reasonable.

The Ombudsman, assisted by his Adviser, found no evidence that clinicians failed to adequately and promptly investigate Mrs B’s loss of vision or that her condition was misdiagnosed. The Ombudsman also found no evidence that Mrs B was prescribed treatment that worsened her condition.

The Ombudsman did not agree that the decision of NHS clinicians not to carry out a surgical procedure to remove/disperse a blood clot was a failing, as it was clinically reasonable to treat Mrs B’s condition

conservatively. The Ombudsman therefore did not agree that Mrs B unfairly incurred expense in having private surgery. However, the Ombudsman did find that there was a failure to refer Mrs B to a vitreo-retinal surgeon at the outset of her

The Ombudsman upheld Mrs B's complaint that she was spoken to inappropriately and dismissively by one of the Consultant Ophthalmologists.

The Ombudsman recommended that the Health Board provide Mrs B with a written apology for the identified communication failings and that it should give consideration to developing referral guidelines so that patients presenting with loss of vision as a result of sub-macular haemorrhage have access to timely vitreo-retinal surgical assessment and advice. The Health Board accepted these recommendations.

[A GP practice in the area of Cardiff & Vale University Health Board – Clinical treatment outside hospital](#) Case Number: 201702580 – Report issued in April 2018

Mr X complained that, during an appointment at the Surgery, the GP not only refused to conduct an examination or offer any treatment for his increased symptoms but created an inaccurate record of the consultation. Mr X also complained that the GP refused to refer him for further treatment that day and interfered with the care he received from the Emergency Department at the local hospital.

The investigation found that the GP's record keeping in this case had been poor and, whilst it had a significant impact on the process, there was sufficient enough information to make it difficult to conclude, with any certainty, what happened during the appointment. The investigation found no evidence that the GP refused to refer Mr X for treatment or attempted to influence the care Mr X received from the hospital clinicians.

It was recommended that the Surgery apologise to Mr X and that the GP undertake a review of the complaint focusing on record keeping and the impact it had on the investigation. It was also recommended that any learning be shared with the other clinicians in the Surgery.

[Betsi Cadwaladr University Health Board – Other](#) Case Number: 201602452 – Report issued in April 2018

Ms X complained about the care given to her late mother, Mrs Y, by Betsi Cadwaladr University Health Board ("the Health Board"). She indicated that the Health Board had not managed the process of diagnosing Mrs Y's bowel cancer properly. Specifically, Ms X complained about the management of Mrs Y's flexible sigmoidoscopy ("the sigmoidoscopy"), Mrs Y's referral for a barium enema investigation ("the barium enema"), the timing of Mrs Y's gastroscopy and the reporting of Mrs Y's barium enema results.

The Ombudsman did not uphold those parts of Ms X's complaint, which concerned Mrs Y's sigmoidoscopy and barium enema referral. He found that Mrs Y's gastroscopy was delayed and upheld that aspect of Ms X's complaint. He noted that the Health Board had misreported Mrs Y's barium enema results, but he did not determine that that error was a service failure. However, he found that the Health Board's response to those results was, in terms of their review, inadequate. He partly upheld that element of Ms X's complaint, which concerned Mrs Y's barium enema results, because of this. He asked the Health Board to apologise to Ms X for the failings identified and to pay her £750 in recognition of their impact. He recommended that it should review its procedure for mitigating the risks associated with not acting on diagnostic results. He also asked the Health Board to remind staff members that sub-optimal investigation results are not sufficient to exclude a diagnosis of cancer. The Health Board agreed to implement these recommendations.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number: 201700914 – Report issued in April 2018

Ms B complained to the Ombudsman that Cwm Taf University Health Board (“the Health Board”) had failed to deal with cataracts she had developed in a timely manner. She was also aggrieved that the Health Board had unreasonably delayed performing surgery on her eyes because of her poorly controlled diabetes. She complained that as a result of these delays she had had to pay for a consultation with a private surgeon who subsequently arranged for her to receive the surgery she needed. Ms B also complained that the Health Board should have known that she had advanced diabetic retinopathy and informed her of this.

The Ombudsman found that there had been a delay in undertaking Ms B’s pre-operative assessment, when a decision was made that she needed cataract surgery, and that there was also an avoidable delay in scheduling surgery on the basis of Ms B’s diabetes being poorly controlled. This delay had led Ms B to decide to arrange a private consultation. The Ombudsman did not uphold the complaint about the Health Board not identifying that Ms B had advanced retinopathy since there was no certainty that this condition would have been identifiable at the time her eyes were examined.

The Ombudsman upheld the complaints about the delays Ms B had experienced and recommended total redress of £1240. He also recommended that the Health Board consider changing the arrangements for carrying out pre-operative assessment of ophthalmic patients.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number: 201701648 – Report issued in April 2018

Ms A complained about the care and treatment provided to her daughter, B, by Hywel Dda University Health Board (“the Health Board”) following her birth on 3 August 2015. Ms A complained that there was a failure to identify an anorectal abnormality (a birth defect where the anus and rectum do not develop properly), despite B’s feeding problems and significant distress, between 3 and 29 August. Ms A also raised concerns that she was not provided with sufficient health visitor or stoma nurse input for B.

The Ombudsman found that the anorectal abnormality should have been diagnosed before B’s discharge from hospital. The distress this caused to Ms A was an injustice, and this element of the complaint was upheld. In relation to Ms A’s concern that she had a lack of health visitor support, the Ombudsman did not uphold this part of the complaint as there was evidence that further support had been available, but Ms A had not responded to telephone messages from health visitors during November 2016 to January 2016. The Ombudsman found that there was a lack of stoma nurse support which would have added to Ms A’s distress. This aspect of the complaint was upheld.

The Ombudsman recommended that the Health Board apologise to Ms A and provide a redress payment of £750 in respect of the distress caused by the delay in diagnosing B and the lack of stoma nurse input. The Health Board were asked to provide evidence of the improvement changes it had made since Ms A’s complaint. The Ombudsman also recommended that relevant staff should be reminded that they should be certain that no abnormalities are detected before this is ‘ticked’ as passed on the neonatal examination document and should only record examination findings if that part of the examination has been performed.

Cardiff and Vale University Health Board – Other

Case Number: 201701319 – Report issued in April 2018

Mrs X complained about the mental health care provided to her husband, Mr X, by Cardiff and Vale University Health Board (“the Health Board”). She complained that the Health Board failed to accept referrals from Mr X’s GP, for a psychiatric assessment of his mental health.

The Ombudsman found that two referrals, sent by Mr X’s GP, for a psychiatric assessment of Mr X’s mental health, were unreasonably declined by the Health Board as they were turned down without appropriate consideration, further discussion or any attempt at clarification with Mr X’s GP.

The complaint was upheld, and a number of recommendations were made.

Cardiff and Value University Health Board – Clinical treatment in hospital

Case Number: 201701433

Mrs X complained that the cause of her abdominal pain was not fully investigated by Cardiff and Vale University Health Board (“the Health Board”) when she attended the Emergency Department of the University Hospital of Wales on 26 April 2016.

The Ombudsman was satisfied that the cause of Mrs X’s abdominal pain was appropriately investigated by the Health Board. However, he concluded that Mrs X’s discharge from the Health Board was not appropriate.

The complaint was partly upheld, and the following recommendations made:

- a) Provide Mrs X with a written apology for its failure to ensure that her discharge from the Hospital was appropriate.
- b) Provide Mrs X with a financial payment in recognition of the uncertainty caused by the failure identified during the investigation.
- c) Remind staff of the importance of undertaking a reasonable period of observation prior to discharge.

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

Case Number: 201700160 – Report issued April 2018

Mrs Y complained that the care and treatment provided to her late father, Mr X, by the Surgery from January to June 2014, was inadequate. Mrs Y also complained that Mr X was prescribed an anti-depressant during this time and said that this was evidence that the GPs at the Surgery did not consider his symptoms seriously.

The Ombudsman found that, when Mr X initially attended the Surgery, the GPs acted appropriately. However, he also found that, at five appointments between April and June the GPs could have to arranged further investigations into Mr X’s symptoms, as well as taken action to expedite a routine scan. The Ombudsman upheld this element of the complaint.

The Ombudsman also found that Mr X’s anti-depressant prescription was for pain relief and was not prescribed in its capacity as an anti-depressant. He did not uphold this element of the complaint.

The Ombudsman recommended that the Surgery write to Mrs Y to apologise for the failings identified and provide a redress payment of £300 to reflect the distress and uncertainty that Mr X experienced. Also, that one of the GPs at the Surgery discuss the case at his next NHS appraisal, as the other GP named in this complaint had retired.

Hywel Dda University Health Board – Continuing care

Case Number: 201700015 – Report issued in April 2018

Mrs X complained, via her Solicitor, on behalf of the estate of the late Mrs Y, about the Independent Review Panel's ("IRP") consideration of Mrs Y's eligibility for NHS funded continuing healthcare ("NHSFCC"). Mrs X was aggrieved that the IRP did not provide sufficient evidence to support the decision that Mrs Y was not eligible for NHSFCC funding for the period August 2009 to July 2011.

The investigation found that there was considerable doubt as to whether the decision taken by the IRP, in respect of Mrs Y's eligibility for NHSFCC, was robust and properly made. The investigation found that there were significant omissions in how the decision was made by the IRP which amounted to maladministration. The injustice resulting from the maladministration was the uncertainty as to whether the outcome would have been different had those omissions not occurred. The complaint was, therefore, upheld. Hywel Dda University Health Board agreed to arrange another IRP to consider the claim.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number: 201700756 – Report issued in May 2018

Mr T complained about the care and treatment his late sister, Mrs M, received from Cwm Taf University Health Board ("the Health Board"). The complaint concerned the failure by the Health Board to discuss with Mrs M whether the surgery she underwent was appropriate and whether it obtained informed consent prior to the surgery and made her fully aware of the risks. Mr T also complained about the quality of the Health Board's complaint response.

The investigation found that Mrs M's medical history was taken into consideration prior to the operation and the consent form indicated clearly that the operation had been discussed with her in full. The consent form and medical notes also showed that Mrs M gave informed consent and the risks had been explained to her.

Finally, the investigation found that the Health Board's complaint response was too brief and did not set out in any detail the issues discussed during an earlier meeting or its final position on each of the concerns originally raised by Mr T. The Ombudsman upheld this element of the complaint and asked the Health Board to apologise to Mr T which it agreed to do.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case number: 201701545 – Report issued in May 2018

Mr X complained about carpal tunnel procedure on his right hand in February 2014. Mr X disputed Betsi Cadwaladr University Health Board's ("the Health Board") claim that he had nerve conduction studies on 26 August which suggested he did not have carpal tunnel syndrome ("CTS"). Mr X also complained about the Health Board's complaint handling.

The Ombudsman found that there was no criticism of the CTS procedure to Mr X's right hand. He found that it should have been recognised that the CTS procedure had failed at Mr X's subsequent June and August appointments and urgent nerve conduction studies arranged, which could have prevented right hand muscle loss. The Ombudsman found that the Health Board's response to Mr X was incorrect; there were no nerve conduction studies at the August appointment. He also found that the Health Board had not followed up Mr X's email and subsequent letter. The Health Board agreed to implement the Ombudsman's recommendations to pay Mr X £1,000 for the failure to have arranged nerve conductive nerve studies and not being placed on the list for further surgery and pay £250 for the failure to have followed up Mr X's email and letter response. The Ombudsman also recommended that the Health Board review why Mr X's

email and responses were not followed up, explains to Mr X why he was not given an appointment after April 2016 and reviews whether there is a need for a carpal tunnel decompression policy when there are no improvements in patient's symptoms.

[Powys Teaching Health Board – Clinical treatment in hospital](#)

[Case Number: 201700446 – Report issued in May 2018](#)

Miss X complained about the care and treatment her mother, Mrs Y, received in hospital in 2014. Miss X was concerned about the lack of rehabilitation; the level of general nursing (specifically personal care and weight loss monitoring); the decision to change dementia medication to sodium valproate ("SV"), an unlicensed drug; the lack of blood monitoring despite Mrs Y receiving blood thinning medication; and the Protection of Vulnerable Adults (POVA) process and complaints handling.

The Ombudsman found no evidence of a plan for rehabilitation. This complaint was upheld. He also found a range of failings in Mrs Y's nursing care which were compounded by poor record keeping. The records did not demonstrate that personal care was robustly undertaken and there were missed opportunities to take corrective action to address Mrs Y's weight loss. This complaint was upheld.

The Ombudsman found that the decision to change medication and prescribe SV was just about within the bounds of reasonable clinical practice. However, he found serious shortcomings in the way this was communicated to the family. The complaint was upheld to this extent.

The Ombudsman found there was no requirement to monitor Mrs Y's blood while being treated with blood thinners. Again, communication with the family about this could have been improved. The complaint was upheld to this extent. He found a number of shortcomings in respect of the POVA process and complaints handling.

The Ombudsman made a number of recommendations including a written apology and an audit of nursing documentation. No redress payment was made in accordance with the views of Miss X.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case Number: 201703229 – Report issued in May 2018](#)

Mrs A complained about her late mother, Mrs B's, management and care while an inpatient on the rehabilitation ward of Wrexham Maelor Hospital. Mrs B claimed that her mother's rapid deterioration was not properly addressed by clinicians. Mrs B was subsequently transferred to the critical care unit where a viral brain infection was identified. Mrs A was also dissatisfied with the Health Board's handling of her complaint including the adequacy of its complaint response.

The Ombudsman's investigation found there were clinical failings including around the application of the clinical escalation assessment tool which would have highlighted that Mrs B was very ill. As a result, the opportunity for further medical review and earlier intervention was lost. The Ombudsman concluded that it was not possible to say whether Mrs B would have lived if the failings had not occurred and this uncertainty was the injustice caused to Mrs A. The Ombudsman upheld this part of Mrs A's complaint.

The Ombudsman found that the investigation by Betsi Cadwaladr University Health Board ("the Health Board") of Mrs A's complaint was insufficiently robust and as a consequence the opportunity to learn lessons was lost. This part of Mrs A's complaint was also upheld.

The Ombudsman's recommendations included the Health Board apologising to Mrs A and making a redress

payment of £1,000 for the uncertainty in relation to her mother's outcome and £250 for the shortcomings in complaint handling.

[Betsi Cadwaladr University Health Board – Other](#)

[Case Number: 201701025 – Report issued in May 2018](#)

Mrs R complained about the actions of the Council and Betsi Cadwaladr University Health Board ("the Health Board") in relation to child protection concerns regarding her granddaughter, A, following a report by A's father that, during a contact visit, he had observed bruising to her leg. Mrs R also complained about the investigation of her complaint, and its outcome.

The Ombudsman found that the Council's actions, taken as a whole, were reasonable, in view of the evidence it had at the time, and the independent investigator's report into Mrs R's complaint was thorough and its conclusions were reasonable. He did not uphold the complaint against the Council.

The Ombudsman also found that the actions of the Health Board's hospital staff were reasonable and did not uphold that part of the complaint. However, the Health Board had not handled Mrs R's complaint appropriately, and he upheld this part of the complaint. The Health Board agreed to apologise to Mrs R for this failing.

[Hywel Dda University Health Board – Clinical treatment in hospital](#)

[Case Number: 201703765 – Report issued in May 2018](#)

Mr G complained about his treatment for a knee injury sustained in an accident, claiming failures to carry out investigations before undertaking surgery for what was believed to be a torn tendon, and the failure to diagnose and treat a haematoma, resulting in nerve damage.

The Ombudsman found that further investigations should have been undertaken before proceeding to surgery which proved to be unnecessary, and he upheld that part of the complaint. The possibility of a haematoma should have been considered, although it did not follow that it would necessarily have been treated and that Mr G would not have gone on to develop nerve damage. The Ombudsman upheld that part of the complaint to the extent that Mr G was left with the uncertainty of not knowing whether the nerve damage might have been avoided.

Hywel Dda University Health Board agreed to apologise to Mr G, provide him with a redress payment of £750, and remind staff members of the learning to be taken from the complaint.

[Cwm Taf University Health Board – Clinical treatment in hospital](#)

[Case Number: 201703155 – Report issued in May 2018](#)

Mrs A complained that following an injury to her head, Cwm Taf University Health Board ("the Health Board") failed to undertake appropriate tests and provide her with a diagnosis. Mrs A also complained that she was inappropriately discharged from hospital without a follow up appointment.

The investigation found that the clinicians, when formulating a diagnosis, focused on the outcome of Mrs A's CT scan and failed to take into account a period of unconsciousness experienced by Mrs A straight after the injury. Additionally, there was no evidence that Mrs A's mobility had been assessed prior to her discharge or that she was given appropriate written advice about head injuries. The investigation also found that, since her test results had been normal, there had been no clinical reason for a hospital admission or to arrange a follow up appointment at her local hospital.

It was recommended that the Health Board apologise to Mrs A for the failings identified in this report and pay her £250 in recognition of the distress caused by the lack of information provided on discharge. It was also recommended that the Health Board remind the Emergency Department staff of the need to ensure that patients are discharged with appropriate written advice and to document what advice is given and that clinicians were reminded of their record keeping responsibilities.

[A Health Centre in Hywel Dda University Health Board – Clinical treatment outside hospital](#)

[Case Number: 201607333 – Report issued in May 2018](#)

Mr X said that Hywel Dda University Health Board (“the Health Board”) and two GP Practices in its area failed to properly monitor his cardiac condition (despite his long-standing and known heart valve issue). He complained that the Health Board failed to properly investigate his symptoms at the Emergency Department of Bronglais Hospital in June 2015 which resulted in his cardiac condition worsening. Mr X also complained that there was a failure to recognise abnormalities in his lungs following a chest X-ray. Finally, Mr X complained that one of the GP Practices failed to diagnose or suspect endocarditis (an infection of the heart) and failed to properly investigate his lung condition (he was later diagnosed with asthma).

The investigation found that other than the GP Practice’s investigation of Mr X’s lung condition, the care provided to Mr X by all parties had been of a reasonable standard. The complaint relating to the investigation of the lung condition was, therefore, upheld but the others were not upheld.

The GP Practice responsible for that failing agreed to apologise to Mr X and to undertake an audit to ensure that the steps it had taken to address the failing had been effective.

[Aneurin Bevan University Health Board – Other](#)

[Case number: 201700939 – Report issued in June 2018](#)

Mr X complained about a failure to follow the correct procedure in progressing his application for funding to transition from female to male as a result of Gender Dysphoria (“GD”). Mr X said that, as a result of the failings complained about, his transition had been avoidably delayed.

The Ombudsman found that the Aneurin Bevan University Health Board Health Board (“the Health Board”) did not follow the applicable policy, which it acknowledged. The Ombudsman concluded that Mr X’s transition pathway had not been significantly delayed, but that Mr X’s own efforts to correct procedural failings were instrumental in this. The Ombudsman concluded that Mr X was left with a degree of uncertainty as to the possible impact of the Health Board’s failings and this constituted an injustice to him.

The Ombudsman upheld the complaint and the Health Board agreed to apologise to Mr X, pay financial redress totalling £500 (split equally between a payment in recognition of the uncertainty he faced and for the time and trouble to which he was put in pursuing his complaint) and undertake a review of all other patients who may have been similarly affected.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case number: 201701763 – Report issued in June 2018](#)

Mr Y complained about his hernia operation at a hospital under Betsi Cadwaladr University Health Board (“the Health Board”) on 19 January 2016. Mr Y said that he was misled into having this procedure by local anaesthetic and the pain he encountered had been excruciating.

The Ombudsman found that there was no criticism about Mr Y’s hernia procedure and that Mr Y was not misled into having this procedure under local anaesthetic. However, he did consider that that the process

of obtaining consent could have been better and the Ombudsman upheld this aspect of the complaint to the limited extent that Mr Y should not have signed his consent on the day of the procedure. This placed pressure on him to agree and had he decided to have the procedure by general anaesthetic the operation would not have gone ahead. The Ombudsman found that Mr Y was administered adequate pain management for this procedure, and he did not uphold this aspect of the complaint.

The Ombudsman recommended that the Health Board apologise to Mr Y for asking him to provide consent on the day of surgery, remind relevant surgical staff that difficulties encountered during a surgical procedure are recorded within the notes of surgery and consider introducing an information leaflet for patients having hernia surgery under local anaesthetic.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case number: 201702728 – Report issued in June 2018](#)

Mr X complained that he was told aspiration of his thyroid cyst would not be continued at a hospital under Betsi Cadwaladr University Health Board ("the Health Board") but he subsequently paid twice privately for the same procedure at the Hospital.

The Ombudsman had no criticism of the decision on 26 September 2016 not to further aspirate Mr X's thyroid cyst. The Ombudsman found that at this appointment Mr X should have been referred for a second opinion, which may have counselled further aspiration. Mr X was only so referred in response to his complaint to the Health Board six months later. The Health Board agreed to implement the Ombudsman's recommendations to apologise to Mr X that he was not referred for a second opinion and reimburse £424, the cost of the private treatments he received.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#)

[Case number: 201700745 – Report issued in June 2018](#)

Ms X complained on behalf of her mother, Mrs A, that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to treat her mother's symptoms when she attended hospital in July 2016. She also complained about the care Mrs A received during her admittance to hospital in August 2016 and said that when she raised her concerns the Health Board failed to properly manage and investigate them.

The Ombudsman upheld all of Ms X's concerns. He found that a lack of records relating to the July attendance made it difficult to evaluate the assessment, although it appeared that Mrs A's pain was not appropriately investigated and treated. He also found that the Health Board failed to recognise, assess and manage Mrs A's delirium when she was admitted to hospital in August and did not manage and monitor her medication and nutrition adequately. It also appeared that there was poor communication with the family and a delay in planning Mrs A's end of life care, which undermined the dignity afforded to Mrs A. Finally, the Ombudsman considered that the Health Board had failed to grasp Ms X's initial complaint, and despite acknowledging some shortcomings failed to adequately consider the effects of them.

The Ombudsman recommended that the Health Board apologise and offer a token financial sum to Ms X for the shortcomings identified and her time and trouble pursuing the complaint. The Ombudsman also recommended that staff be reminded of the importance of timely communication and given training on record keeping. He recommended further training on the recognition and risk assessment of delirium, and that the Health Board review its current guidelines to ensure they reflect best practice on preventing, diagnosing and managing delirium and provide a procedure for specialist input where required.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case number: 201701737 – Report issued in June 2018

Ms A complained about the care her father (“Mr C”) received between June and July 2016, in particular the level of sedation he was prescribed and failures in monitoring his delirium, hydration, incontinence and nutrition. Ms A also complained that the Health Board inappropriately considered and applied for Deprivation of Liberty Safeguards (“DoLS”)¹ without consulting the family. Ms A further complained that the Betsi Cadwaladr University Health Board (“the Health Board”) failed to manage and respond to her complaint and her request to receive copies of her father’s health records.

The Ombudsman accepted that some sedation was necessary to alleviate the symptoms of Mr C’s dementia and found that the Health Board appropriately considered the risks and benefits of sedation and used a number of alternative interventions, including reassurance, distraction and pain relief, alongside it. He therefore did not uphold this complaint. The Ombudsman also found that, whilst there were unacceptable omissions within the health records, the care provided was appropriate and clinically reasonable.

Whilst the Ombudsman acknowledged that it was appropriate to apply for DoLS, in case Mr C attempted to leave the ward and would need to be detained, he was concerned that there appeared to have been some confusion as to the purpose of DoLS, and that this legislation had been confused with “best interests” decisions about Mr C’s care. Additionally, he could not conclude with certainty that the DoLS application, and its implications, had been appropriately discussed with Mr C’s family.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case number: 201701883 – Report issued in 2018

Mrs B complained that the Aneurin Bevan University Health Board (“the Health Board”) failed to appropriately care for her father (“Mr X”) following his knee operation and inappropriately discharged him from hospital when he was suffering from injury of the small intestine owing to restricted blood supply. Mrs B also complained that the Health Board failed to manage her concerns and respond to her complaint appropriately.

The investigation found that the Health Board failed to monitor and respond to Mr X’s condition, who should have been reviewed by a doctor over the weekend. However, there was no evidence that the decision to discharge him was inappropriate. Notwithstanding, inadequate record keeping made it difficult for the Ombudsman to conclude that Mrs B’s concerns, and decisions made about them, were addressed and noted that her worry might have been alleviated if the notes had accurately recorded the reasoning for decisions made about Mr X’s care. Furthermore, the response to Mrs B’s formal complaint was unduly delayed and actions the Health Board had already taken, in respect of wider learning, were not communicated effectively to her.

The Ombudsman recommended the Health Board apologise to Mrs B and offer financial redress to reflect her worry and uncertainty as a result of the inadequate record keeping and her time and trouble in pursuing the complaint. He also recommended that the Health Board remind relevant staff of the importance of full and accurate record keeping, timely investigations and effective communication. Finally, he requested evidence that the Health Board has adequate arrangements in place for review by a doctor on weekends and bank holidays.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case number: 201702365 – Report issued in June 2018

Mr A complained about the Betsi Cadwaladr University Health Board's ("the Health Board"):

- a) Inappropriate and unsafe discharge home of Mrs A on 18 June, and her subsequent deterioration and re-admittance on 20 June.
- b) Failure to diagnose whether Mrs A's infection was sepsis or a chest infection, and the delay in treatment led to Mrs A's deterioration and premature death.
- c) Poor complaints handling.

The investigation found that Mrs A's discharge home was premature and that the Ombudsman concluded that Mrs A's discharge should have been delayed. The Health Board missed opportunities to conduct a focussed examination of Mrs A's chest and had the Health Board taken account of Mrs A's initial physiotherapy assessment, indications were present that Mrs A was not ready to be discharged. In addition, the Health Board omitted to repeat Mrs A's observations prior to her discharge which might have indicated whether she had been developing a chest infection at that stage.

The Ombudsman upheld this part of Mr A's complaint but acknowledged he could not say with any degree of certainty whether Mrs A's infection might have been identified had these omissions not occurred. Also, the Ombudsman upheld Mr A's complaint about the Health Board's complaints handling which did not comply with relevant timescales and did not address Mrs A missing nursing records in its final response to the complaint.

The investigation found that Mrs A's infection was diagnosed and treated in a timely manner and this issue was not upheld. The Health Board agreed to implement the Ombudsman's recommendations to address the shortcomings identified.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital

Case number: 201701636 – Report issued in June 2018

Mr A complained about his late son, Mr B's management and care by Betsi Cadwaladr University Health Board's ("the Health Board") Community Mental Health Team. Mr B died from an overdose in October 2015 while a resident at a drug rehabilitation unit not managed by the Health Board. Mr A felt his son's outcome could have been different if a proper care plan had been put in place. In addition, Mr A also complained about communication with him, the Health Board's handling of its serious incident review ("SIR") and failings in the Health Board's handling of his complaint.

The Ombudsman's investigation concluded that where clinical shortcomings had occurred in Mr B's care, they had not directly contributed to the sad outcome in this case. Therefore, the Ombudsman did not uphold this part of Mr A's complaint. The Ombudsman did identify shortcomings around communication and complaint handling and to that extent only upheld these parts of Mr A's complaint.

The Ombudsman, as well as recommending that the Chief Executive apologise to Mr A, on behalf of the family, for the failings identified, also made recommendations related to training and process changes.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case number: 201703376 – Report issued in June 2018

Mr A complained about the management and care he had received from the cardiac services at a hospital under Abertawe Bro Morgannwg University Health Board ("the Health Board"). He was also dissatisfied with the Health Board's handling of his complaint.

The Ombudsman's investigation identified missed opportunities to properly assess Mr A's care, given that there were indications that he was likely to require a permanent pacemaker. He concluded that aspects of Mr A's care had been poor, and this extended to communication with him. He was also critical of poor record-keeping practices that were evident at the Hospital. The Ombudsman upheld this part of Mr A's complaint.

The Ombudsman also identified shortcomings in the Health Board's handling of Mr A's complaint and upheld this part of Mr A's complaint.

The Ombudsman's recommendations included the Health Board apologising to Mr A for the failings, providing additional training and continuing with changes to its record-keeping processes.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#)

[Case number: 201702464 – Report issued in June 2018](#)

Mr B complained about the care and treatment he received at Gastroenterology Department of a hospital under Abertawe Bro Morgannwg University Health Board ("the Health Board") where he was referred with symptoms of weight loss and abdominal/bowel pain. Mr B complained that:

A Consultant Gastroenterologist failed to adequately examine him and suggested that his symptoms were an indication of Irritable Bowel Syndrome (IBS). However, within days, Mr B was admitted to the Hospital with a perforated bowel (as a complication of Crohn's Disease) for which he underwent emergency surgery. Mr B complained that the Consultant therefore failed to identify that his condition was potentially life-threatening

A stool sample analysis and a CT scan were ordered by the Consultant, but only because he was prompted to do so by Mr B and his mother, Mrs B.

The Consultant attempted to contact Mrs B shortly after the consultation, with the aim of offering to admit Mr B to the Hospital. Mr B considered that this breached his right to confidentiality and indicated that the Consultant had, in retrospect, recognised the serious nature of his condition

The Health Board failed to provide a formal written response to Mr B's complaint, as it was incorrectly assumed that his concerns had been resolved at a meeting held with Health Board personnel on 9 May 2017.

The Ombudsman did not uphold Mr B's substantive complaint that the Consultant failed to identify symptoms of Crohn's Disease. The Ombudsman, assisted by his clinical adviser, considered that the examination/assessment that Mr B received was reasonable and thorough and that Mr B's symptoms were suggestive of IBS. Whilst the Consultant did arrange for Mr B to undergo tests to determine whether he had Crohn's Disease, there were no clinical signs that he was about to suffer a perforated bowel.

The Ombudsman partially upheld Mr B's complaint surrounding the Consultant choosing to contact his mother (a clinician who had been present during the consultation). Whilst there was no evidence that the Consultant had revised his diagnosis, the Ombudsman determined that there was a failure to properly explain to Mr B that he (the Consultant) had made this offer as a professional courtesy to a colleague.

The Ombudsman upheld Mr B's complaint that the Health Board failed to provide him with a formal written response under PTR Regulations. The Ombudsman supported the Health Board's decision to offer Mr B a £250 ex-gratia payment in recognition of this shortcoming.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case number: 201701023 – Report issued in June 2018

Mrs X complained about the care her daughter, Ms A, received from the Cardiff and Vale University Health Board (“the Health Board”). Mrs X complained that Ms A should have been admitted to hospital for inpatient treatment, not discharged home for treatment. Mrs X also complained that the care plan created for Ms A after discharge was inadequate and that there had been a delay in providing Ms A with the support she required.

The investigation found that, whilst the support Ms A received had been consistent with Welsh Government guidance, decisions relating to care should have been better explained to Ms A and her family. The investigation also found that there had been a delay in the Health Board providing Ms A with the care and support she required.

It was recommended that the Health Board apologise to Mrs X and Ms A for the failings identified. It was also recommended that the Health Board pays Mrs X £250 in recognition of the time and trouble in bringing her complaint to this office and pays Ms A £500 in recognition of the delays in implementing her care plan. Finally, it was recommended that the Health Board undertakes a full review of Ms A’s care plan to ensure that all identified support is being provided and, where that is not possible, a suitable alternative has been identified and offered.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case number: 201705183 – Report issued in June 2018

Mrs A complained that, having been referred to the Emergency Department (“ED”) on 23 November 2016 by her Optician, the ED Ophthalmologist at the hospital failed to make an appropriate diagnosis and provide treatment.

The investigation found that, given the concerns raised by the Optician about the pressure levels in Mrs A’s eyes and the limited equipment available at the time of the examination, Mrs A should have been referred to a specialist eye clinic for further investigations.

It was recommended that Betsi Cadwaladr University Health Board apologise to Mrs A for the failings identified and pay her any out of pocket expenses that she has incurred as a result of seeking private ophthalmology treatment.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case number: 201701491 – Report issued in June 2018

Mr B complained to the Ombudsman on behalf of Mr A’s family about the care and treatment Mr A had received from Abertawe Bro Morgannwg University Health Board (“the Health Board”). Mr A was a patient at a Mental Health ward of a hospital under the Health Board in March 2016. Mr B was concerned that staff failed to act on a deterioration in Mr A’s physical health. Mr B was also concerned that Mr A was discharged inappropriately both in terms of his mental and physical health needs. Mr B was also concerned about the manner in which hospital staff dealt with conflict between Mr A and another patient. Sadly, two days following his discharge from hospital, Mr A died of a heart attack. He was found to have pneumonia and hypertension.

The Ombudsman found that there was no evidence in the clinical notes to suggest a deterioration in Mr A’s physical health during the admission. He also found that whilst Mr A’s psychiatric symptoms appear to have

settled somewhat, the Health Board failed to undertake an appropriate mental state examination and to prepare an appropriate discharge plan. Accordingly, whilst the Ombudsman did not uphold the complaint that the Health Board failed to act on a deterioration in Mr A's general health he upheld the element of the complaint relating to the manner in which the Health Board managed Mr A's discharge from a Mental Health perspective. The Ombudsman found the manner in which the Health Board managed Mr A's conflict with another patient to be reasonable and did not uphold that element of the complaint.

The Ombudsman recommended an apology and redress of £250 to Mr A's widow for a failure to communicate appropriately with her at the time of Mr A's discharge. He also recommended that the Health Board reminds staff to undertake and document appropriate mental health assessments prior to discharge and to undertake an audit to ensure such actions were taking place.

[Aneurin Bevan University Health Board – Clinical treatment in hospital](#)

[Case number: 201703075 – Report issued in June 2018](#)

Mrs A complained to the Ombudsman about the adequacy of the actions Aneurin Bevan University Health Board ("the Health Board") had taken to address shortcomings it had identified in the care of her late father (Mr B) whilst he was nursed on a dementia ward. She was also concerned that Mr B's nutritional needs had not been monitored or managed appropriately while on the ward and was also dissatisfied with the manner in which the Health Board had dealt with the family's concerns.

Whilst the Ombudsman welcomed some of the actions taken by the Health Board to address the shortcomings identified, he considered that some were insufficient and therefore upheld the complaint. Also, due to the passage of time and the poor completion of fluid and nutritional charts, he was unable to determine whether Mr B's nutritional care had been appropriate. He also found that the Health Board had failed to take notes at a complaint resolution meeting and to provide the family with a summary setting out the outcome of the meeting. He upheld this aspect of the complaint.

The Ombudsman recommended the Health Board apologise and provide redress of £350 for failing to demonstrate that it learned from the shortcomings Mr B's family had brought to its attention and redress of £150 for failing to take adequate notes of the meeting and to send the family an appropriate summary afterwards.

[Cardiff and Vale University Health Board – Clinical treatment outside hospital](#)

[Case number: 201606772 – Report issued in June 2018](#)

Ms A complained about the standard of mental health care provided to her son, Mr B, while he was in prison. The investigation considered whether the assessments of Mr B's mental health undertaken during his prison stay were appropriate.

The Ombudsman found that Cardiff and Vale University Health Board ("the Health Board") failed to take into account relevant information provided by Ms A and, had it done so, an assessment may have been conducted by a psychiatrist. It is not possible to know whether, if it had done so, Mr B's subsequent diagnosis may have been made earlier, but this uncertainty was an injustice to Ms A and Mr B.

The Health Board agreed to apologise to Mr B and to change its process to ensure that prisoners receive an appropriate psychiatric assessment which takes into account concerns raised by those who know the patient. It also agreed to ensure that appropriate testing for illicit substances is undertaken as part of the mental health assessment process.

Not Upheld

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case number: 201705636 – Report issued in April 2018](#)

Mrs A's complaint centred on the management and care that her son, Child B received when he attended the Emergency Department ("ED") at Wrexham Maelor Hospital ("the Hospital") in October 2016. She was unhappy that the seriousness of her son's infection in his left hand was not recognised by clinicians in the ED. Mrs A was also dissatisfied with the Health Board's handling of her complaint and the robustness of its complaint response.

The Ombudsman's investigation confirmed that the care that Child B received at the ED was broadly reasonable and therefore this part of Mrs A's complaint was not upheld. In terms of complaint handling, the Ombudsman was satisfied that the Health Board's response was reasonably robust. Whilst there were steps the Health Board could have taken which would have improved its handling of Mrs A's complaint, the Ombudsman concluded that these shortcomings were not sufficient to have amounted to maladministration. The Ombudsman did not uphold this part of Mrs A's complaint.

[Aneurin Bevan University Health Board – Patient list issue](#)

[Case Number: 201700239 – Report issued in April 2018](#)

Mr X complained that Aneurin Bevan University Health Board ("the Health Board") failed to treat him within a clinically appropriate timescale and exceeded the Welsh Government's 36-week referral to treatment time. Mr X said that his GP made a referral to the Health Board on 13 December 2016, and that he was informed he would have to wait 85 weeks for surgery. Mr X's surgery was carried out until 2 October 2017, a total waiting time of nearly 42 weeks. Mr X also complained that at an appointment with an Orthopaedic Surgeon on 10 February 2017, he failed to inform him of a four-month delay for a painkilling injection.

The Ombudsman was disappointed to note that, when it was first decided that Mr X needed surgery, he was informed that the waiting time was 85 weeks. However, the Ombudsman determined that although the Health Board exceeded the RTT target time of 36 weeks, the target does not have statutory or regulatory status and does not, therefore, provide the patient with an absolute right to treatment within the 36 weeks. Thus, the Health Board's failure to meet the RTT target did not amount to service failure. Additionally, there was no evidence to suggest that Mr X's wait for surgery could be attributed to clinical mismanagement of his case and there was no clinical justification for Mr X's surgery to be expedited. Given that Mr X was no more disadvantaged by the time he spent on the waiting list than the other patients who were equally affected by the breached target, the Ombudsman did not uphold Mr X's complaint.

The Ombudsman found that he was unable to establish what was discussed between Mr X and the Consultant at the appointment of 17 February 2017 and was therefore unable to make a finding on this element of the complaint.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case Number: 201701496 – Report issued in April 2018](#)

Mrs Y complained that, at two separate appointments in May 2014, Betsi Cadwaladr University Health Board ("the Health Board") failed to refer her late father, Mr X, for clinical investigations that might have led to an earlier cancer diagnosis.

Mrs Y also complained that Health Board policy in 2014 prevented her father from being directly referred for an MRI scan by his GP when he presented with back pain.

The Ombudsman found that the care and treatment provided at both May appointments was of a reasonable standard and in line with good practice and medical guidelines. He did not uphold this element of the complaint.

Further to this, the Ombudsman found that since Mrs Y's complaint, the Health Board had developed a new spinal care pathway from primary to secondary care. The Ombudsman found that, if the new pathway had been in place at the time of Mr X's treatment, it would have allowed for Mr X to have been referred directly for an MRI scan, if he had been categorised as having 'red flag' symptoms. As this issue had been addressed by the Health Board, there was nothing further that the Ombudsman could achieve for Mrs Y and, therefore, no finding was made in relation to this element of her complaint.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#)

[Case Number: 201703788 – Report issued in May 2018](#)

Mr A complained that Aneurin Bevan University Health Board ("the Health Board") failed to provide adequate treatment following his knee injury in 2014 and that there were excessive delays in providing subsequent treatment. Mr A also complained about poor communication in terms of complaint handling.

Overall, on the evidence considered, the Ombudsman found that the care provided to Mr A was reasonable and appropriate and did not uphold this aspect of Mr A's complaint.

In relation to Mr A's concerns about the delay, the Ombudsman's investigation concluded that whilst the time that Mr A spent on the waiting list clearly exceeded the Welsh Government's referral to treatment target ("RTT") of 36 weeks, as it does not have statutory or regulatory status it does not confer on a patient an absolute right to treatment within the 36-week timeframe. He concluded that Mr A was no more disadvantaged by the time he spent on the waiting list than the many other patients who were also adversely affected by the delay. He therefore did not uphold this aspect of Mr A's complaint.

Finally, in relation to Mr A's concerns about complaint handling, the Ombudsman considered that the Health Board had provided a detailed response to Mr A and that complaint handling was reasonable and timely. Again, he did not uphold this aspect of Mr A's complaint.

[Cwm Taf University Health Board – Clinical treatment in hospital](#)

[Case Number: 201701664 – Report issued in May 2018](#)

Mrs B complained about Cwm Taf University Health Board's ("the Health Board") poor management of her care in 2013/2014, for symptoms associated with her menstrual cycle, including her premature discharge to primary care in 2014. Mrs B specifically complained that this led to a delay in the identification of a lump in her colon until May 2016 and led to her emergency bowel surgery and subsequent colostomy reversal surgery in 2016.

The investigation found that the clinical care Mrs B received, including her discharge to primary care in 2013/2014, was both reasonable and appropriate based on her presenting symptoms and test results at that time. In addition, it was found that the care and treatment Mrs B received in 2014 had no clinical impact on the subsequent clinical events and outcome in 2016. The Ombudsman did not uphold Mrs B's complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number: 201702277 – Report issued in May 2018

Mrs X complained about the treatment her husband, Mr X, received in hospital when undergoing a surgical procedure. She complained that the risks of the procedure were not properly explained, pre-operative tests were inadequate, the effect of Mr X's blood thinning medication was not properly considered, the procedure was not stopped following a bleed and Mr X was prematurely discharged home.

The Ombudsman found that although there were some shortcomings in the taking of consent and pre-operative medication review, the overall standard of care provided was adequate. The Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number: 201700586 – Report issued in May 2018

Ms A complained about the outpatient treatment, which Cardiff and Vale University Health Board ("the Health Board") gave her late father, Mr B, for psoriatic arthritis. Her complaint concerned the Health Board's decision to treat that condition with methotrexate, its continued use of that treatment and its monitoring of it.

The Ombudsman determined that the Health Board's decision to treat Mr B with methotrexate was fitting. He found that it was not clinically necessary for the Health Board to stop Mr B's methotrexate treatment whilst he was an outpatient. He established that the Health Board had monitored Mr B's methotrexate treatment appropriately. He did not uphold Ms A's complaint.

Hywel Dda University Health Board – Clinical treatment in hospital

Case Number: 201607330 – Report issued in May 2018

Mr X said that Hywel Dda University Health Board ("the Health Board") and two GP Practices in its area failed to properly monitor his cardiac condition (despite his long-standing and known heart valve issue). He complained that the Health Board failed to properly investigate his symptoms at the Emergency Department of Bronglais Hospital in June 2015 which resulted in his cardiac condition worsening. Mr X also complained that there was a failure to recognise abnormalities in his lungs following a chest X-ray. Finally, Mr X complained that one of the GP Practices failed to diagnose or suspect endocarditis (an infection of the heart) and failed to properly investigate his lung condition (he was later diagnosed with asthma).

The investigation found that other than the GP Practice's investigation of Mr X's lung condition, the care provided to Mr X by all parties had been of a reasonable standard. The complaint relating to the investigation of the lung condition was, therefore, upheld but the others were not upheld.

The GP Practice responsible for that failing agreed to apologise to Mr X and to undertake an audit to ensure that the steps it had taken to address the failing had been effective.

A GP practice in the area of Hywel Dda University Health Board – Clinical treatment outside hospital

Case Number: 201607334 – Report issued in May 2018

Mr X said that Hywel Dda University Health Board ("the Health Board") and two GP Practices in its area failed to properly monitor his cardiac condition (despite his long-standing and known heart valve issue). He complained that the Health Board failed to properly investigate his symptoms at the Emergency Department of Bronglais Hospital in June 2015 which resulted in his cardiac condition worsening. Mr X also complained that there was a failure to recognise abnormalities in his lungs following a chest X-ray. Finally, Mr X complained that one of the GP Practices failed to diagnose or suspect endocarditis (an infection of the heart) and failed to properly investigate his lung condition (he was later diagnosed with asthma).

The investigation found that other than the GP Practice's investigation of Mr X's lung condition, the care provided to Mr X by all parties had been of a reasonable standard. The complaint relating to the investigation of the lung condition was, therefore, upheld but the others were not upheld.

The GP Practice responsible for that failing agreed to apologise to Mr X and to undertake an audit to ensure that the steps it had taken to address the failing had been effective.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#)

[Case number: 201703785 – Report issued in June 2018](#)

Mrs X complained about the care and treatment her late father, Mr X, received in hospital in November/December 2016 where, sadly, he died. Mrs X complained about various delays and inadequacies in her father's treatment, including radiotherapy, diagnostic procedures and pain relief.

The Ombudsman found that, although there were some delays in Mr X's treatment, they were not excessive and did not result in an adverse clinical outcome. Overall, the Ombudsman found that Mr X's treatment was appropriate and there was no evidence to suggest that the ultimate outcome could have been altered. The Ombudsman did not uphold the complaints.

[Aneurin Bevan University Health Board – Clinical treatment outside hospital](#)

[Case number: 201704106 – Report issued in June 2018](#)

Mrs X complained about the care her son, Mr X, received in the weeks leading up to a mental health crisis, during which he was arrested several times, imprisoned and detained in hospital. Mrs X complained that this could have been avoided had adequate and appropriate support, intervention and treatment been provided earlier.

The Ombudsman found that, overall, the care and support provided was of a good standard. He found that Mr X's care was appropriately planned and delivered, but that Mr X did not fully engage with his proposed treatment. The Ombudsman found that although Mr X's mental health deteriorated during the period complained about and acknowledged that Mr X ended up in crisis, this was not as a result of any significant shortcomings in his care. The Ombudsman did not uphold the complaint.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)

[Case number: 201704332 – Report issued in June 2018](#)

Mr X complained that there was an unacceptable delay in carrying out his wife's, Mrs X, left total hip replacement surgery. He also complained that the surgery was not undertaken to an adequate standard and that a postoperative procedure to investigate the source of pain had been delayed.

The Ombudsman found that, although there was a delay in Mrs X's surgery, no adverse clinical outcome resulted. He found that the surgical techniques employed were appropriate and that the post-operative procedure, whilst delayed, was not urgent. The Ombudsman did not uphold the complaint.

[Cwm Taf University Health Board – Clinical treatment in hospital](#)

[Case number: 201704923 – Report issued in June 2018](#)

Mrs X complained that there was an unacceptable delay in treatment for her husband's eye condition in December 2016 and March 2017. She complained that, as a result, he had been left with irreparable loss of sight.

The Ombudsman found that the treatment provided had been appropriate and there were no significant clinical failings. The Ombudsman did not uphold the complaint.

[Betsi Cadwaladr University Health Board – Appointments/ admissions/ discharge and transfer procedures](#) [Case number: 201702153 – Report issued in June 2018](#)

Mr A complained about the delay in accessing the Pain Clinic. He said that he should have been prioritised as he had severe back pain and could not take anti-inflammatory or certain pain medication due to a gastric condition.

The Ombudsman's investigation concluded that the failure to offer Mr A treatment within the timescale allowed by the waiting time rules did not amount to maladministration as the target is not mandatory. He was satisfied that Mr A was correctly placed on the waiting list and that his clinical need had been appropriately considered. The Ombudsman, while noting the situation was distressing for Mr A, was satisfied that in Mr A's case the delays in treatment times were driven by the length of the waiting list. In the absence of any evidence of service failing or maladministration, the Ombudsman did not uphold Mr A's complaint.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#) [Case number: 201702741 – Report issued in June 2018](#)

Mr D complained to the Ombudsman that, following referral to Abertawe Bro Morgannwg University Health Board's ("the Health Board") Urologists with a significantly raised PSA level and an enlarged prostate gland, he was incorrectly diagnosed with prostate cancer. Mr D complained that clinicians failed to consider the possibility that he was suffering with Prostatitis (inflammation of the prostate gland) and failed to consider how an MRI scan (obtained at a private hospital outside the UK) found no evidence of prostate cancer. Mr D also complained about numerous inaccuracies in his medical records and suggested that the test results informing his diagnosis may have been mixed up with those of another patient.

The Ombudsman did not uphold Mr D's complaint. Through his Clinical Adviser, he found that the diagnostic investigations conducted by Health Board clinicians confirmed (at the biochemical, clinical, pathological and radiological levels) that Mr D had been correctly diagnosed with prostate cancer.

The Ombudsman agreed that there were some inaccuracies in the information contained in Mr D's medical records, but found no evidence to support Mr D's suggestion that his records and/or test results may have been mixed up with those of another patient and no evidence that these inaccuracies gave rise to any adversity or injustice to Mr D.

The Ombudsman encouraged Mr D to seek appropriate treatment for his condition at his earliest opportunity.

[Health Centre in the Cwm Taf University Health Board area – Clinical treatment outside hospital](#) [Case number: 201701538 – Report issued in June 2018](#)

Mrs B complained about the care given to her late husband, Mr B, by a GP Surgery in the area of Cwm Taf University Health Board ("the Health Board"). She reported that the GPs involved ("the GPs") failed to respond to Mr B's acid reflux symptoms appropriately on several occasions. She said that the diagnosis of Mr B's oesophageal cancer was delayed because of these failings.

The Ombudsman found that the GPs had responded satisfactorily to Mr B's acid reflux symptoms. He did not uphold Mrs B's complaint.

Powys Teaching Health Board – Continuing care

Case number: 201702350 – Report issued in June 2017

Mrs C complained that, when considering a retrospective claim for NHS Continuing Healthcare Funding for a relative, Powys Teaching Health Board's ("the Health Board") Clinical Advisor and Independent Review Panel did not appropriately consider the evidence in this case and that some needs were overlooked. Mrs C also complained that there was not enough detail in the Retrospective Review Decision Document on the reasons why the eligibility criteria had not been satisfied.

The Ombudsman found the evidence was appropriately considered and identified had not been overlooked. There were some administrative omissions, but this did not impact on the final decision, all the expected eligibility tests had been applied and the conclusions were clinically reasonable. The Decision Document adequately evidenced the information and key clinical facts, which were analysed during the Independent Review Panel and whilst some of the reflection of the discussion was sparse the minor omissions did not amount to maladministration. The complaint was not upheld.

Early Resolution and Voluntary Settlements

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number: 201705623 – Report issued in April 2018

Mrs X complained to the Ombudsman that, although Aneurin Bevan University Health Board ("the Health Board") had provided her with a formal response to a complaint that she submitted about a healthcare matter, it had failed to provide her with a further response (which it had undertaken to provide) to her outstanding concerns. Given that the Health Board indicated that its further response was in preparation, the Ombudsman considered it reasonable to allow the Health Board to issue this response in the hope that it will help to resolve the complaint.

The Health Board has therefore agreed:

- a) To provide Mrs X with this response within four to six weeks.

The Ombudsman is satisfied that the agreed action will provide an early resolution to this complaint.

Hywel Dda University Health Board – Clinical treatment outside hospital

Case number: 201707379 – Report issued in April 2018

Mr B complained that Hywel Dda University Health Board ("the Health Board") had failed to take care and provide adequate treatment for him via one of its General Practitioner Surgeries ("the Surgery"). The complainant alleged that the General Practitioner ("the GP") who spoke with him on 2 separate occasions was dismissive of his suggestion as to the cause of his respiratory congestion condition and failed to prescribe antibiotics to treat it. He also complained that the Surgery failed to advise him of the next stage of the Health Board's complaints procedure and a delay in responding to his complaint.

The Ombudsman found that there was no apparent service failure regarding his case and treatment. He did, however, approach the Health Board regarding the issues regarding the complaint handling.

The Health Board agreed to;

- a) Write to Mr B and apologise for not advising him of the next stage in the complaints procedure.
- b) Confirm that necessary steps had been put implemented to ensure that complainants are advised of the procedure in future.

The Health Board has completed this and the Ombudsman is satisfied that its actions have resolved his complaint.

[A Dental Practice in the area of Betsi Cadwaladr University Health Board - Appointments/ admissions/ discharge and transfer procedures](#)

[Case Number: 201706668 – Report issued in April 2018](#)

Mrs D complained to the Ombudsman that she required dental work at an additional cost to her, as a possible result of root canal treatment carried out at the Dental Practice. Mrs D also complained that she received a dissatisfactory complaints response from the Dental Practice

Although the Ombudsman declined to investigate Mrs D's complaint, he recognised that the Dental Practice had not clearly demonstrated that it had considered Mrs D's complaint under the "Putting Things Right" arrangements.

Because of this, he contacted the Dental Practice and it agreed to do the following within six weeks:

- a) Re-investigate the complaint in line with 'Putting Things Right', to include a review of all relevant documentation.
- b) Provide a full written apology to Mrs D for the shortcomings in the initial investigation.

[A medical centre in the area of Betsi Cadwaladr University Health Board – Clinical treatment outside hospital](#)

[Case Number: 201706203 – Report issued in April 2018](#)

Mr A complained that his GP's attitude during a consultation was inappropriate and that the examination, diagnosis and treatment recommended by the GP were not of a reasonable standard. Mr A complained that the GP failed to diagnose a more serious condition, namely pneumonia. Mr A further complained that the Medical Centre's written response to his complaint was inaccurate as it stated that he was admitted to hospital due to an allergic reaction.

Due to the lack of independent evidence and having obtained some preliminary professional advice, the Ombudsman declined to investigate the complaints about the GP's attitude, or the examination, diagnosis and treatment. However, the Ombudsman identified that there was an error in the complaints response.

He contacted the Medical Centre and it agreed to provide a meaningful apology to Mr A for any distress caused to him due to the inaccurate recording of the reason for his admission to hospital, which, in turn, resulted in this information being contained within its complaint response.

[Cardiff and Vale University Health Board – Clinical treatment in hospital](#)

[Case Number: 201707057 – Report issued in April 2018](#)

Mr B complained that his late father was inappropriately given bilateral knee replacement surgery, and then received poor care post-surgery. Mr B also raised concerns over a lack of communication from the Consultant regarding his father's care. A meeting was held between Mr B and the Clinical Care Team, at which Cardiff and Vale University Health Board ("the Health Board") had agreed to provide a timeline of care. However, no follow-up had been forthcoming, or a response to the concerns Mr B had raised.

The Ombudsman found that the Health Board should have noted Mr B's dissatisfaction at the meeting and provided a formal response to his concerns under PTR.

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

- a) Issue a formal response letter to Mr B within 6 weeks.

- b) Provide the timeline which was agreed to at the meeting, with an apology for the delay in providing it, within 28 days.
- c) Offer financial redress in recognition of the 13 months delay from the time of the meeting, in the sum of £250, within 6 weeks.

Powys Teaching Health Board – Continuing Care

Case Number: 201706889 – Report issued in April 2018

Mr A complained about Powys Teaching Health Board's "the Health Board" decision that his late wife, Mrs B, was not eligible for NHS Continuing Healthcare in respect of her residential care fees for the period 30 September 2013 to 30 December 2014.

On receipt of the complaint, the Ombudsman contacted the Health Board setting out Mr A's concerns. Although the Health Board was satisfied that the evidence had been properly applied in Mrs B's case, it acknowledged that some information relating to multiple entries evidencing the same care needs had not been recorded within its assessment documents. For the avoidance of doubt and in settlement of the complaint, it agreed to incorporate the additional information and to submit the claim for further review, in accordance with the process, to identify if there were triggers for the claim to be considered further.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number: 201706356 – Report issued in April 2018

Ms A complained about the care and treatment provided to her late mother (Mrs B) at the Royal Gwent Hospital, and the way Aneurin Bevan University Health Board ("the Health Board") handled her concerns. Ms A said Mrs B fell because she was not properly supported whilst transferring from wheelchair to bed. She also said staff were abrupt and unprofessional when she tried to raise her concerns, and a doctor did not review Mrs B for eleven days following the incident. Ms A was dissatisfied with the Health Board's formal complaint response and said it got Mrs B's name wrong.

Although the Ombudsman declined to investigate Ms A's complaint, he recognised that the Health Board had accepted in its formal complaint response that there were shortfalls in Mrs B's care and treatment for which it apologised. However, it appeared that the Health Board had got Mrs B's name wrong, and not adequately addressed Ms A's concerns about Mrs B's mobility and support requirements. 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) Send an apology to Ms A for getting Mrs B's name wrong.
- b) Provide an explanation to Ms A about why Mrs B did not receive an urgent review from a doctor following the incident.
- c) Provide an explanation to Ms A about how Mrs B's mobility and patient handling was assessed.
- d) Take steps to consider how staff attitudes can be improved following incidents or complaints on the ward.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number: 201701591 – Report issued in April 2018

Mr X complained that he had not been told to stop taking anticoagulation medication prior to a planned prostate biopsy, despite specifically asking the Health Board if he should do so; this meant that Mr X attended for the biopsy, which had to be postponed as Mr X was still taking his medication.

Betsi Cadwaladr University Health Board agreed to;

- a) remind surgical staff of its anticoagulation policy.

- b) review information provided to patients before surgery regarding continuing to take anticoagulation medication.
- c) remind secretaries to show correspondence to clinicians.

The Ombudsman discontinued his investigation into the complaint.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#)

[Case Number: 201706846 – Report issued in April 2018](#)

Mrs X made a complaint against Abertawe Bro Morgannwg University Health Board (“the Health Board”) that during her operation on 17 March 2017, the surgeon failed to remove her kidney stones which resulted in her having to undergo further surgery. Mrs X said that the second operation was delayed due to her being placed on the routine list for surgery rather than the urgent list; this resulted in Mrs X seeking private medical treatment. Finally, Mrs X complained that there had been a failure to adequately respond to her complaint.

Having been informed of the complaint, the Health Board accepted that there had been some points of concern and agreed to settle the complaint by:

- a) Apologising to Mrs X for the failings it had identified.
- b) Providing Mrs X with an explanation of what had happened as well as what action the Health Board had since taken to ensure that those failings were not repeated.
- c) Reimbursing Mrs X’s out of pocket expenses.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#)

[Case Number: 201701549 – Report issued in May 2018](#)

Mrs A complained about the care and treatment her husband received at Singleton Hospital (“the Hospital”) on 28 February 2017, following cataract surgery. She also complained that the delay in identifying and treating her husband’s eye infection meant he lost vision in that eye, underwent further surgery, and needed a prosthetic eye. The Ombudsman’s investigation identified delay in treating Mr A’s eye infection after cataract surgery. He concluded it was highly unlikely that Mr A’s eyesight could have been saved due to the virulence of the infecting organism. However, had the delay not occurred it might have been possible to avoid additional surgical treatment and the need for a prosthetic eye. Abertawe Bro Morgannwg University Health Board (“the Health Board”) acknowledged this failing. The Ombudsman asked the Health Board to consider proposing a settlement and based on its consideration of the individual facts of this case it proposed the following terms of settlement:

- a) apologise for the delay in diagnosing and treating Mr A’s eye infection.
- b) pay a redress sum of £40,000 in full and final settlement.
- c) review the procedures in place for deterioration in post-operative patients.
- d) review the complaint handling in this case and present the findings of the review to the Health Board’s Assurance & Learning Group.

The Ombudsman considered this to be an appropriate outcome to the investigation. Mr and Mrs A accepted the Health Board’s offer of settlement. The investigation was discontinued.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case number: 201800674 – Report issued in June 2018

Mrs A complained about Aneurin Bevan University Health Board's ("the Health Board") decision to stop offering her lumbar epidural injections. Mrs A complained that the other treatments she had tried did not relieve her pain, while the injections improved her quality of life considerably.

Although the Ombudsman declined to investigate Mrs A's complaint, he was concerned that Mrs A's pain was not being managed.

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

- a) To refer Mrs A to the pain clinic to consider whether any further treatment or management is available for the pain she experiences in her spine.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside of hospital

Case number: 201706734 – Report issued in June 2018

Mrs X made a complaint against Abertawe Bro Morgannwg University Health Board ("the Health Board") regarding the end of life care provided to her late husband, Mr X, who sadly passed away on 1 September 2016, after a diagnosis of primary lung cancer.

The Ombudsman found that the Health Board had provided a reasonable response to the concerns that Mrs X had raised however, the actions and recommendations proposed in remedy of her complaint had not been fully implemented. Mrs X had expressed a lack of confidence that they would be followed through.

The Ombudsman contacted the Health Board and it agreed to the following in settlement of the complaint:

- a) To provide both Mrs X and the Ombudsman with an up to date action plan within one calendar month of the date of this decision.
- b) To provide evidence to the Ombudsman of its compliance with the action plan until he is satisfied that the actions have been met.

Medical practice in the Aneurin Bevan University Health Board area – Clinical treatment outside hospital

Case number: 201800019 – Report issued in June 2018

Mr A complained about the delay in providing him with medication for angina, a Glyceryl Trinitrate Spray, which had been prescribed by secondary care services. Because of this, he said he suffered unnecessary pain and discomfort over a 6/7-month period.

Having considered the matter, the Ombudsman identified that the GP Practice had acknowledged the omission and apologised that it was not done in a timely manner. However, the Ombudsman did not consider that this action was sufficient to fully address the injustice caused to Mr M.

Because of this, the Ombudsman contacted Aneurin Bevan University Health Board and it agreed to carry out the following, within one month, in settlement of the complaint:

- a) to provide Mr A with a clear explanation of how the oversight occurred and to confirm what action it had taken/intends to take to avoid similar issues from occurring in the future.
- b) to provide Mr A with a redress payment of £350.

Abertawe Bro Morgannwg University Health Board – Patient list issues

Case number: 201800906 – Report issued in June 2018

Mr B complained that Abertawe Bro Morgannwg University Health Board (“the Health Board”) had failed to provide him with hip treatment within a reasonable timescale. Mr B also complained about the Health Board’s handling of his complaint.

The Ombudsman found that Mr B formally complained to the Health Board, and that the Health Board had acknowledged the complaint and provided a leaflet explaining The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (“the Regulations”) process. However, the Health Board subsequently failed to provide a formal response to Mr B’s complaint.

The Health Board agreed to complete the following actions by 3 August 2018 in settlement of Mr B’s complaint:

- a) Consider and respond to Mr B’s complaint in accordance with the Regulations.
- b) Apologise that Mr B’s complaint did not receive a formal response.

Hywel Dda University Health Board – Clinical treatment in hospital

Case number: 201801140 – Report issued in June 2018

Mr X complained that, during a surgery in January 2018, it was discovered that packing had been left in his face following an operation to his cheek performed by Hywel Dda University Health Board (“the Health Board”) in 1990.

Mr X made his complaint to the Health Board in March 2018. The Health Board confirmed that it had been unable to obtain any record of treatment provided to Mr X prior to 1994.

In raising his complaint with the Ombudsman, Mr X provided information which had previously not been disclosed to the Health Board.

In settlement of the complaint, the Health Board agreed to complete the following actions by 25 July 2018:

- a) Obtain Mr X’s medical records from his GP.
- b) Consider Mr X’s GP records and the additional information he provided to the Ombudsman in order to decide whether an investigation under the ‘Putting Things Right’ Regulations is possible.

Cardiff and Vale University Health Board – Patient list issues

Case number: 201801176 – Report issued in June 2018

Mr X complained that he was discharged without his surgeon’s knowledge, has waited over three and a half years for an operation, and that Cardiff and Vale University Health Board (“the Health Board”) has ignored his letters, along with letters sent by his Assembly Member, and his doctor.

The Ombudsman found that the Health Board had failed to acknowledge or respond to Mr X’s complaint of February 2018. The Health Board therefore agreed to complete the following actions by 3 August 2018 in settlement of Mr X’s complaint:

- a) Apologise to Mr X for failing to acknowledge or reply to his complaint.
- b) Provide a reply to Mr X’s complaint in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
- c) Offer a payment of £250 to Mr X for the time and trouble in making his complaint to the Ombudsman.

Hywel Dda University Health Board – Appointments/ admissions. Discharge and transfer procedures Case number: 201801332 – Report issued in June 2018

Mrs X complained that Hywel Dda University Health Board (“the Health Board”) informed her in its complaint response of December 2017 that she could arrange an appointment with a Consultant Vascular Surgeon, but that this has not occurred.

Mrs X also complained that the Health Board had failed to acknowledge or respond to her further concerns made in April 2018.

In settlement of Mrs X’s complaint, the Health Board agreed to complete the following actions by 9 August 2018:

- a) Apologise for failing to respond to Mrs X’s further concerns.
- b) Issue a response to the further concerns Mrs X has raised.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case number: 201801029 – Report issued in June 2018

Mr X complained about the delay in treatment he received after arriving at hospital following an incident when he dislocated his artificial hip joint.

Cardiff and Vale University Health Board (“the Health Board”) advised the Ombudsman that it was not able to address Mr X’s complaint in full as aspects of it related to services provided outside of its control. The Health Board advised that it sent a consent form to Mr X to allow it to contact the alternative service providers to obtain information to allow it to answer all concerns raised.

After carefully considering the complaint it was noted that the Health Board failed to explain this process to Mr X nor did it chase him for his consent. It has therefore agreed to undertake the following actions to settlement of this complaint:

- a) Write to Mr X explaining why it was not able to respond in full and apologise for omitting this information.
- b) Provide a further consent form and opportunity to have the issues addressed.

A dentist in the Betsi Cadwaladr University Health Board area – Clinical treatment outside hospital Case number: 201800856 – Report issued in June 2018

Mr C complained that he had been overcharged for care following a tooth extraction in August 2017. Mr C said that he had understood he would also be given a new denture on that course of treatment. However, when he returned to the practice five months later, and underwent a further tooth extraction and impression for a new denture, he was charged full price. Mr C had raised concern with the dentist, and received a response stating that the charges were correct. However, when he wrote again requesting that his complaint be looked into further, he did not receive any additional response.

The Ombudsman cannot consider the fees and charges for dental treatment as these are set down in the NHS (Dental Charges) (Wales) Regulations. However, he considered that Mr C should have received a response to his two further letters of complaint.

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

- a) Apologise for failing to respond to Mr C’s two subsequent letters.
- b) Offer an ex-gratia refund for the first extraction.

Cardiff and Vale University Health Board – Patient list issues

Case number: 201707805 – Report issued in June 2018

Ms A complained about delays in a uterine artery embolization procedure to remove fibroids being carried out and the impact that this had on her.

In responding to the Ombudsman, Cardiff and Vale University Health Board (“the Health Board”) said the Radiology Department was working on an electronic referral system which it hoped would be place by the end of the year. The Health Board felt the new referral system would help prevent a recurrence of the administrative error that led to a delay in the initial referral being actioned.

The Health Board agreed to the Ombudsman’s proposal to pay Ms A a redress payment totalling £350. Additionally, it agreed to apologise to Ms A again for the failing and provide the Ombudsman’s office with an update on progress with the electronic referral system.

Complaints Handling

Early Resolution and Voluntary Settlement

Newport City Council – Various Other

Case Number: 201707309 – Report issued in April 2018

Mr F complained that Newport City Council (“the Council”) failed to respond to a letter he had sent on 20 January 2018. He also said that the Council had not provided a response to a safeguarding concern which had been sent to the Council at around the same time.

The Ombudsman found no evidence that the Council had received the letter of 20 January. Whilst there was evidence of some delays on the part of the Council in its handling of the safeguarding concern, a response was issued on 15 March.

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

- a) Apologise for the apparent delay, from the time Mr F’s safeguarding concerns were sent to the Council until its final decision on 15 March, and explain the reason for it.
- b) Provide a Stage 2 response¹ to both the letter of 20 January and Mr F’s outstanding complaints regarding the safeguarding concern.

Aneurin Bevan University Health Board – Health

Case Number: 201707453 – Report issued in April 2018

Ms X complained about the many issues (mainly communication) which she had experienced when accessing treatment and support from her Community Mental Health Team (“the Team”) in 2016. She was concerned that she had not received a copy of her care plan. She was also concerned about the complaints response received. She said that she had been recently referred to her GP following a missed appointment letter, despite contacting the Team to confirm she had not received the original appointment letter.

The Ombudsman concluded that most of the complaints were out of time for consideration by his office. However, there were some aspects of the complaint that were within time, namely Aneurin Bevan University Health Board’s (“the Health Board”) complaints responses and the appointment letter.

Because of this, the Ombudsman contacted the Health Board and it agreed to carry out the following, within one month, in settlement of the complaint:

- a) to provide Ms X with a further and better explanation about the rationale for her discharge in 2016.
- b) Provide an explanation for the apparent inconsistency in the complaints responses about being placed on the waiting list for psychology support.
- c) Provide Ms X with a copy of her current care plan.
- d) Provide a further explanation about the conclusions reached following Ms X’s ‘recent assessment’.

Betsi Cadwaladr University Health Board – Health

Case Number: 201706664 – Report issued in April 2018

Ms X complained that Betsi Cadwaladr University Health Board (“the Health Board”) responded to her concerns before receiving the results of treatment which was carried out in December 2017. She also complained that it failed to respond to her question regarding financial loss as her Life Insurance Policy was cancelled because of its failure to notify her of results in June 2015 (affecting the terms of her insurance cover).

When acknowledging Ms X's complaint, the Health Board asked for further information but also advised that the matter "[had] been forwarded to those investigating [the] concern so that it can be considered as part of the investigation". The complaint was subsequently closed as it did not receive the required information from Ms X. With respect to Ms X's care and treatment, the Health Board also acknowledged a breach of duty by failing to follow up on appointments, since 2015, relating to a lesion.

The Ombudsman considered that it was for the investigating team to follow up on the outstanding information, if required, to complete its investigation of the insurance issue before providing the Health Board's overall response. The complaint response did not refer to the insurance issue at all.

The Health Board had also failed to acknowledge the distress Ms X undoubtedly suffered given the urgent referral and further procedure required, resulting from its initial failure to follow up on the 2015 test results.

The Health Board therefore agreed to carry out the following actions:

- a) To use all reasonable endeavour to seek any additional information required from Ms X to consider the outstanding issue in her complaint and to respond to that issue within one month of receipt.
- b) To offer Ms X a further apology and redress of £250 for the acknowledged failure to provide her with timely follow up appointments and the resulting distress suffered by needing an urgent referral and an excision procedure in December 2017.

Torfaen County Borough Council – Other miscellaneous Case Number: 201707453 – Report issued in April 2018

Mrs G complained to the Ombudsman that Torfaen County Borough Council ("the Council") breached personal data by sending an email to all employees, to inform them of the death of Mrs G's family member and how that person had died. Mrs G was unhappy with how the Council responded to the concerns raised.

Although the Ombudsman declined to investigate the alleged breach of personal data, he recognised that there had been confusion and shortcomings in the Council's complaint handling. Because of this, he contacted the Council and it agreed to do the following within one month:

- a) to provide a full written apology to Mrs G for the confusion and shortcomings in its complaints handling.

Hywel Dda University Health Board – Health Case Number: 201707324 – Report issued in April 2018

Ms A complained about the handling of her complaint about the care she has been provided by Hywel Dda University Health Board ("the Health Board"). Ms A also complained that the Health Board had failed to provide a copy of her medical records.

Ms A's Community Health Council advocate complained to the Health Board in June 2017. Whilst the Health Board proactively provided updates to Ms A initially, subsequent updates had been chased by Ms A's advocate.

In settlement of Ms A's complaint, the Health Board agreed to complete the following actions by 17 May 2018:

- a) Provide its response to Ms A's complaint.
- b) Apologise for the delay in responding to Ms A's complaint.
- c) Offer a payment of £125 to Ms A in recognition of the delay and the time and trouble in making the complaint to the Ombudsman.
- d) Provide Ms A's medical records to her.

Cwm Taf University Health Board – Health

Case Number: 201707530 – Report issued in April 2018

Ms X complained that Cwm Taf University Health Board (“the Health Board”) had failed to respond to the complaint she had made to it in November 2017 regarding a Hysteroscopy which she underwent.

The Health Board had informed Ms X that its complaint response would be issued by 22 February 2018. Ms X subsequently chased the Health Board for an update. The Health Board apologised for the delay and provided an update to Ms X on 27 February.

Ms X escalated her complaint to the Ombudsman’s office on 28 February. The Health Board agreed to undertake the following actions in settlement of Ms X’s complaint:

- a) Expedite the complaint response.
- b) Continue to provide monthly updates to Ms X during its investigation.

The Health Board issued a further update to Ms X on 6 April and issued its complaint response on 12 April, evidencing its compliance with the above agreed actions.

Ammanford Town Council – Various other

Case Number: 201708045 – Report issued in April 2018

Mr X complained that Ammanford Town Council (“the Council”) had failed to respond to his complaint, made to it on 21 December 2017, regarding unpublished Minutes for the Council’s meetings held since August 2016.

Mr X’s complaint had been hand-delivered to the Council. Following correspondence with the Ombudsman’s office, the Ombudsman also provided the Council with an electronic copy of Mr X’s complaint on 9 February 2018.

Mr X complained to the Ombudsman’s office on 27 March 2018 that he was still to receive a response from the Council. The Council confirmed to the Ombudsman that its failure to respond was an “admin error” on its part.

The Council therefore agreed to complete the following actions by 27 April 2018 in settlement of Mr X’s complaint:

- a) Issue the response to Mr X’s complaint.
- b) Apologise for the delay in responding to Mr X’s complaint.
- c) Offer a payment of £125 to Mr X in recognition of the delay in responding to his complaint, and for the time and trouble in making his complaint to the Ombudsman.

Hywel Dda University Health Board – Health

Case Number: 201707686 – Report issued in April 2018

Ms X initially raised a complaint with Hywel Dda University Health Board (“the Health Board”) in June 2017 and received its response in July 2017. After considering the Health Board’s response, Ms X raised further concerns but complained to the Ombudsman in March 2018 as she had still not received a final response from the Health Board.

The Ombudsman contacted the Health Board which advised that the response had been drafted and sent for approval and signing. It agreed to issue the letter no later than 13 April and the Ombudsman considered that agreement to be a reasonable resolution of the complaint made to him. It is the Ombudsman’s understanding that Ms X has now received that letter.

Hywel Dda University Health Board – Health

Case Number: 201707859 – Report issued in April 2018

Ms X complained that, at the time of submitting her complaint to the Ombudsman, she had not received a response from Hywel Dda University Health Board (“the Health Board”) to a complaint she raised with it in July 2017.

The Ombudsman contacted the Health Board to discuss the concerns and its progress into the complaint. It advised that a response had been prepared but matters had arisen that required further consideration. It agreed to undertake the following:

- a) Send Ms X a meaningful update and explanation for the delay.
- b) Apologise for the delay.
- c) Provide a date when Ms X can expect to receive the response or, if this is not possible, an idea of the next steps and promise regular updates.

The Health Board has provided its assurances that it is progressing with its investigations and is ensuring that its response will be comprehensive.

Powys Teaching Health Board – Health

Case Number: 201707452 – Report issued in April 2018

In April 2017, Mrs Y complained, via an Advocate, about the care her later father had received from Powys Teaching Health Board (“the Health Board”) between September and November 2015. The Health Board had agreed to investigate the complaint, but no response had been forthcoming.

The Ombudsman found that, as the Health Board had agreed to accept the complaint through PTR, the delay in issuing its response was unacceptable. The Health Board agreed to undertake the following actions by 6 April 2018, in settlement of the complaint:

- a) Provide an apology, and explanation for, the delay.
- b) Commit to pro-actively update Mrs Y on at least a monthly basis until the matter is resolved.
- c) Offer financial redress in the sum of £125 in recognition of the prolonged nature of the complaint.

Brackla Community Council – Other

Case Number: 201707309 – Report issued in April 2018

Miss H complained that Brackla Community Council (“the Council”) had refused to respond to her formal complaint, despite having held a committee meeting to discuss it. Miss H had sent an email to the Council on 11 December raising concerns but did not receive a substantive response. On 18 January Miss H was advised that the Council would not treat her concerns as a complaint because they were “nonspecific and covered several issues”.

The Ombudsman identified that, in her email, Miss H had raised four specific concerns that should have been acknowledged and should have received a response. Furthermore, he found that the number of issues being raised by a complainant is immaterial to whether they have a legitimate right to raise a complaint. He acknowledged that the Council’s failure to deal with Miss H’s concerns appropriately contributed to her loss of trust in the complaints procedure, and the Council.

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

- a) Apologise for failing to deal with Miss H’s complaint appropriately.

- b) Identify an independent person to investigate the complaint and act as Miss H's point of contact in this matter.
- c) Provide a full and final response to the concerns.

Neath Port Talbot County Borough Council – Children's social services

Case Number: 201706648 – Report issued in April 2018

Mr A complained that the Neath Port Talbot County Borough Council ("the Council") had refused to escalate his complaint to stage two of its corporate complaints process.

He also complained that the Council had categorised him as an unreasonable and persistent complainant, restricting the way in which he can communicate with the Council.

The Council has agreed to undertake the following to settle Mr A's complaint with the Ombudsman:

- a) To undertake a stage two review of Mr A's complaint.
- b) To conduct a review of Mr A's classification as an unreasonable and persistent complainant, providing him with an explanation of the rationale for the decision taken.

The Ombudsman expects these actions to be completed within three months.

Neath Port Talbot County Borough Council – Various other

Case Number: 201707398 – Report issued in May 2018

Mr B complained that Neath Port Talbot County Borough Council ("the Council") acted unreasonably by allowing debris to remain on Council-owned land next to his home, which he said allowed access to his garden and which he believed resulted in thefts of his property. He also complained about the delay in the debris being removed after the Council had agreed as a "gesture of goodwill" to remove it. Mr B also complained about the Council's complaints handling.

The Ombudsman noted that the debris was removed whilst the complaint was being considered by his office. Although he declined to investigate the majority of Mr B's complaint, he was concerned that one aspect had not been independently investigated.

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

- a) To apologise to Mr B for the errors in the handling of his complaint.
- b) To undertake a further investigation of this aspect of the complaint by an alternate member of staff in line with the Council's Corporate Comments, Compliments and Complaints Policy.

Powys County Council – Various other

Case Number: 201800406 – Report issued in May 2018

Mr X complained that the Monitoring Office of Powys County Council ("the Council") had failed to respond to his letter of concerns regarding a Community Council in its area.

The Council provided evidence that Mr X's letter had been issued a response in general terms; however, the response had been emailed to an incorrect address.

In settlement of Mr X's complaint, the Council agreed to complete the following action by 15 June 2018:

- a) Reconsider Mr X's letter dated 29 January 2018 and write directly to him to provide a further response.

Vale of Glamorgan Council – Roads and transport

Case Number: 201800021 – Report issued May 2018

Mr X complained about the way in which Vale of Glamorgan Council (“the Council”) handled his complaint about obstructive parking on a grass verge.

In responding to the Ombudsman’s request for information, the Council reviewed its correspondence with Mr X and concluded that it had failed to respond to Mr X’s complaint in a reasonable timeframe.

Therefore, the Council agreed to complete the following actions in settlement of Mr X’s complaint, and confirmed it would do so by

29 May 2018:

- a) Apologise for failing to deal with the complaint at Stage 1 of its complaints procedure previously.
- b) Consider the complaint at Stage 2 of the complaints procedure and respond to Mr X directly.

Powys Teaching Health Board – Health

Case Number – 201800516 – Report issued in May 2018

Mr X complained that Powys Teaching Health Board (“the Health Board”) had failed to identify and manage the deterioration of an ulcer on his mother’s foot which he said led to her death. Mr X also complained about the Health Board’s handling of his complaint.

The Health Board received Mr X’s complaint on 22 January 2018 and informed him that a response would be issued by 6 March. The Health Board subsequently provided Mr X with four updates and apologised for the continued delay in issuing its complaint response.

The Health Board agreed to complete the following by 22 June in settlement of Mr X’s complaint:

- a) Issue the complaint response.

Vale of Glamorgan Council – Finance and taxation

Case Number: 201707699 – Report issued in May 2018

Miss A complained about the way Vale of Glamorgan Council (“the Council”) dealt with her requests for information in respect of her Council Tax account, and how it handled her complaint. She said it provided her with details which were not transparent and were inconsistent. Miss A was dissatisfied with the Council’s complaint response and said it had failed to take her concerns seriously.

Although the Ombudsman declined to investigate Miss A’s complaint, he recognised that the Council had endeavoured to provide Miss A with information and had also recommended a meeting to explain the matters she raised. However, it appears a meeting did not take place, and the information she received was confusing and failed to adequately address her concerns. Because of this, he contacted the Council and it agreed to do the following within one month of the date of this decision

To provide Miss A with an explanation as to why the information she requested has not been supplied in the format she required and apologise if what has been provided has been confusing.

To arrange for an experienced member of staff to meet with Miss A to discuss the processes followed by the Revenues Section, explain the information she has received, and answer any queries she has.

Hywel Dda University Health Board – Health

Case Number: 201708099 – Report issued in May 2018

Ms X complained that after submitting a complaint Hywel Dda University Health Board (“the Health Board”) she was advised that it anticipated responding to her within three months. However, six months later she had still not received its response.

The Ombudsman contacted the Health and was advised that a response letter had been sent for final approval and it was hopeful it would be issued shortly.

The Health Board agreed to issue its final response or its interim response, to Ms X no later than 25 May 2018.

Hywel Dda University Health Board – Health

Case number: 201800842 – Report issued in June 2018

Ms B complained that Hywel Dda University Health Board (“the Health Board”) had refused to allow her to bring a complaint to them and had lied and attempted to discredit her. Ms B also complained that the Health Board had de-registered her from her GP surgery without her knowledge or consent, that they had failed to provide a new GP, and that they had refused to provide her with any treatment for newly diagnosed illnesses, including a thyroid condition.

The Ombudsman did not find any evidence that the Health Board had de-registered Ms B from her GP Practice without her knowledge of consent, failed to provide her with a GP, or refused to provide her with care and treatment for her illnesses. The Ombudsman did not find any evidence that the Health Board had infringed Ms B’s privacy.

Although the Ombudsman declined to investigate Ms B’s complaint, he was concerned that confusion had arisen between the Health Board, Ms B and the Ombudsman’s office regarding how Ms B was to raise new complaints about her care and treatment.

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

- a) To offer Ms B an apology for any distress she had experienced as a result of confusion over who to make a complaint to, and stress that it was never the Health Board’s intention to prevent her from making a complaint to them.

Bron Afon Community Housing – Housing

Case number: 201800578 – Report issued in June 2018

Ms F complained about Bron Afon Community Housing’s (“the Housing Association”) failure to recognise and respond to her complaint. A number of correspondence had passed between them and had been dealt with as an informal invoice query. The Housing Association should have noted Ms F’s dissatisfaction and request for her concerns to be dealt with as a formal complaint.

The Housing Association has 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 not acknowledging Ms F’s concerns formally.
- b) Issue a formal response to the issues raised.

Betsi Cadwaladr University Health Board – Health

Case number: 201801455 – Report issued in June 2018

Dr P complained about the care and treatment provided to his late grandmother whilst she was a patient under Betsi Cadwaladr University Health Board's ("the Health Board") care. He was concerned that the Health Board had failed to address part of his complaint regarding an injury she sustained to her right shoulder.

The Ombudsman found that the Health Board had not addressed the issue surrounding the shoulder injury complained of. The Health Board was contacted and agreed to:

- a) Write a letter of response to the complainant specifically addressing the right shoulder injury sustained by his late grandmother.

This will be completed within 20 working days of the date of my decision letter to the complainant.

The Ombudsman considers that this will resolve the complaint at this stage.

Powys Teaching Health Board – Health

Case number: 201801608 – Report issued in June 2018

Mr X complained that Powys Teaching Health Board ("the Health Board") has failed to respond to his complaint made in February 2018 about a GP Practice in its area.

The Ombudsman found that the Health Board provided an update by letter in March and responded to two telephone enquiries from Mr X in May and June.

The Health Board agreed to complete the following actions by 18 July:

- a) Issue the response to Mr X's complaint.
- b) Apologise to Mr X for the delay in responding to his complaint.

Abertawe Bro Morgannwg University Health Board – Health

Case number: 201801161 – Report issued in June 2018

Ms X complained about the nursing care provided to her husband after reconstructive surgery and neck dissection after he was diagnosed with Oral Cancer.

After carefully considering the complaint the Ombudsman noted that Ms X had not received a response to her concerns. He therefore contacted Abertawe Bro Morgannwg University Health Board ("the Health Board") and was advised that there had been some delays, but a response had been drafted and sent for approval.

The Ombudsman is happy to note that Ms X has now received the Health Board's response and has been advised that if she remains dissatisfied she can bring her complaint back.

Welsh Ambulance Services NHS Trust – Health

Case number: 201708073 – Report issued in June 2018

Ms M complained about the way in which the Welsh Ambulance Services NHS Trust ("WAST") dealt with complaints she made between December 2017 and March 2018. At the time of bringing the complaint to the Ombudsman, she had made seven complaints to WAST via its complaints App. She complained that only her initial complaint was acknowledged, and the other complaints were not dealt with.

Upon assessing the information available, the Ombudsman felt that there was an opportunity for the matter be resolved in a manner which was agreeable to all parties. WAST therefore agreed to undertake the following in settlement of her complaint:

- a) Look into what information WAST already has about Ms M's concerns.
- b) Add to the above by liaising with Ms M and/or her Advocate to clarify what other matters need clarification.
- c) Make a PTR response to incorporate all of those matters promptly.
- d) Provide Ms M with an idea of how long the PTR response is expected to take.
- e) Apologise for any delay in dealing with Ms M's complaints.

Education

Early Resolution and Voluntary Settlement

Carmarthenshire County Council – Special Educational Needs (SEN)

Case Number: 201706608 – Report issued in April 2018

Ms X complained that Carmarthenshire County Council (“the Council”) had continuously failed to provide a Physics tutor for her 15-year-old daughter. Her concerns were as a result of her daughter’s school mishandling her education which led to a breakdown and several suicide attempts. Ms X’s daughter has been diagnosed as having Atypical Autism.

Although the Council had taken steps to resolve this complaint, since the Ombudsman’s involvement, it had failed to formally acknowledge and deal with the complaint under its complaints procedure despite Ms X clearly indicating that she was raising a formal complaint. The Council agreed to write to Ms X with its apologies.

Environment and Environmental Health

Early Resolution and Voluntary Settlement

Vale of Glamorgan Council – Refuse collection, recycling and waste disposal

Case Number: 201800349 – Report issued May 2018

Mr D complained that Vale of Glamorgan Council (“the Council”) had failed to collect recyclable refuse. Mr D made a number of calls to the Council however each call was dealt with as an “on the spot” enquiry. The Council should have noted Mr D’s dissatisfaction and dealt with his concerns as a formal complaint.

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

- a) Apologise and offer a meeting to explain the refuse collection arrangement within one month of the date of my decision.
- b) Investigate to determine the reasons for the missed collections and issue a timely Stage 2 response.

Gwalia Housing – Noise and other nuisance issues

Case number: 201800626 – Report issued in June 2018

Mr B complained that his landlord, Gwalia Housing (the “Housing Association”), had not provided him with reasonable assistance in relation to noise nuisance caused by students residing at the HMO property next door to his home. Mr B also complained that repairs to his property had not been completed in a timely manner, and that he had been provided with incorrect information in relation to his right to buy or acquire his home.

Although the Ombudsman declined to investigate Mr B’s complaint, he was concerned that misleading information had been provided to Mr B in relation to his right to acquire his home.

Because of this he contacted the Housing Association who agreed to do the following:

- a) To apologise to Mr B and his family for providing unclear and incorrect information regarding the right to buy or to acquire his home.
- b) To provide a full, reasoned explanation to Mr B and his family regarding whether or not he would be eligible to apply to acquire his property under the right to buy or acquire schemes, together with the relevant forms (if appropriate).

Housing

Upheld

Vale of Glamorgan Council – Group or block repair/ improvement grants (NOT DFGs)

Case number: 201606791 – Report issued in June 2018

Ms X complained that the Vale of Glamorgan County Council (“the Council”) had failed, either in a timely fashion or at all, to complete the previously agreed schedule of rectification work to her property.

The Ombudsman found that although the schedule of work had been completed, there had been significant delays in doing so, largely as a result of poor workmanship by the contractors engaged by the Council to undertake the work on its behalf. The Ombudsman partly upheld the complaint and recommended that the Council should apologise to Ms X and make a payment to her of £450, comprised of £350 in recognition of the delays experienced and £100 in respect of her time and trouble in pursuing the complaint.

Early Resolution and Voluntary Settlement

Wrexham County Borough Council – Other

Case Number: 201707212 – Report issued in April 2018

Mr A and Miss B, owner occupiers, complained about damage caused to their property when Wrexham County Borough Council (“the Council”) had carried out work to an adjoining property. In addition, they were unhappy with the Council’s proposals for addressing the damage to the party wall in the loft.

The Council agreed to take the following steps to settle Mr A and Miss B’s complaint:

- a) provide a written apology.
- b) make a payment of £650 in recognition of the distress, inconvenience and reasonable quantifiable losses incurred by Mr A and Miss B.
- c) the Council would review the Party Wall Act process and consider whether it needed to alter or improve any of its processes.
- d) a schedule with timescales for completing outstanding works to be agreed with Mr A and Miss B. In the event of dispute the Council would cover the costs of getting an agreed independent person to inspect and make recommendations.
- e) cover the costs of an independent surveyor appointed by Mr A and Miss B who would advise on the remedial work needed to the party wall. Additionally, it would follow the Party Wall Act 1996 dispute mechanism.
- f) following receipt of the independent advice, the Council would reach an agreed settlement on the works to be undertaken and completed. The Council could inspect any completed work within a reasonable time.

Newport City Homes – Repairs and Maintenance (inc. dampness/ improvements and alterations e.g. central heating, double glazing)

Case Number: 201707308 – Report issued in April 2018

Mr C complained that Newport City Homes (“the Housing Association”) had failed to respond to his complaint and claim for compensation, following damage to two leasehold properties he currently rents out. The properties are managed by the Housing Association and the structure of the roof had moved, allowing water ingress which, ultimately, led to the ceiling collapsing.

The Ombudsman found that although a Stage 1 response had been issued, Newport City Homes had

failed to note Mr C's dissatisfaction from his subsequent correspondence. Therefore, did not deal with his concerns under Stage 2 of its formal complaint procedure.

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

- a) Within 28 days from the date of the Ombudsman's decision, to issue an apology letter.
- b) Within one month from the date of the Ombudsman's decision to issue a Stage 2 written response.
- c) Offer financial redress in recognition of Mr C's time and trouble in pursuing the complaint, in the sum of £125.

[Cardiff County Council – Repairs and maintenance \(inc. dampness/ improvements and alterations e.g. central heating, double glazing\)](#)

[Case Number: 2018000475 – Report issued in April 2018](#)

Miss X complained that she had been charged a rechargeable repair fee of £135 by Cardiff County Council ("the Council") for electrical work, but that she had not been informed of the possibility of being charged when she had contacted the Council.

The Council, in its complaint response to Miss X, agreed that Miss X was not informed of the possibility of a call-out fee when she reported the fault. However, the Council decided that the charge should remain as the fault was caused by Miss X's washing machine.

In response to the Ombudsman's enquiries, and having reviewed the complaint, the Council agreed that Miss X should not have been charged.

Therefore, in settlement of the complaint, the Council agreed to complete the following actions by 15 May 2018:

- a) Apologise for the distress caused to Miss X.
- b) Cancel the call-out charge and inform Miss X of its cancellation in writing.

[Flintshire County Council – Repairs and maintenance \(inc. dampness/ improvements and alterations e.g. central heating, double glazing\)](#)

[Case Number: 201707906 – Report issued May 2018](#)

With the assistance of Shelter Cymru, Ms A complained that her landlord, Flintshire County Council ("the Council"), had failed to explain why it did not accept responsibility for damage caused to her property when works were undertaken on its behalf by an independent contractor as part of the Council's capital works programme.

The Council said that it was not responsible for damage/loss experienced and advised Ms A to pursue matters directly with the contractors.

The Ombudsman agreed that despite requests the Council had not fully explained its responsibilities in respect of the works undertaken or offered suitable assistance to Ms A to resolve matters with the contractors (if appropriate).

The Council therefore agreed to escalate Ms A's concerns to step 2 of its Complaints Process and investigate and respond to Ms A according to its published timescales (20 working days).

[Cartrefi Cymunedol Gwynedd – Repairs and maintenance \(inc. dampness/improvements and alteration e.g. central heating, double glazing\)](#)

[Case number: 201800194 – Report issued in June 2018](#)

Mr B complained that Cartrefi Cymunedol Gwynedd (“the Housing Association”) acted unreasonably because it took two years to complete a number of repairs Mr B had requested at his property. Mr B noted that the Housing Association had apologised to him and explained the cause of the delay and had offered a 10% reduction in his net rent for six months of each affected year.

Although the Ombudsman declined to investigate Mr B’s complaint, he was concerned that the offered reduction in rent did not reflect the inability of Mr B to use part of his property for the entire duration of each affected year, and did not refer to the two-year delay in relation to two other repairs reported by Mr B.

Because of this he contacted the Housing Association who agreed to do the following:

- a) To offer the complainant a financial redress payment of £1,036.00, made up of a 10% reduction in the rent paid by the complainant for the entirety of the two years when the first repair was outstanding, plus £50 for each of the other two repairs.
- b) To provide the complainant with an explanation of what led to the failure to process the original request for a repair together with an explanation of what systems have been put in place to avoid further issues of this nature occurring in the future.

[Cadwyn Housing Association Ltd – Repairs and maintenance \(inc. dampness/ improvements and alterations e.g. central heating and double glazing\)](#)

[Case number: 201801222 – Report issued in June 2018](#)

Mr G complained about Cadwyn Housing Association’s (“the Housing Association”) failure to respond to his complaint, despite a number of correspondences from him, expressing his concerns. The Ombudsman found that the Housing Association should have recognised and responded to Mr G’s concerns as a formal complaint.

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

- a) Apologise for the delay in response.
- b) Issue a formal Stage 2 response to the issues raised.
- c) Offer financial redress in the sum of £125 for Mr G’s time and trouble in pursuing the complaint.

[Ateb Group – Neighbour disputes and anti-social behaviour](#)

[Case number: 201800760 – Report issued in June 2018](#)

Mr B complained that Ateb Group (“the Housing Association”) had failed to deal with issues of anti-social behaviour and noise caused by his neighbour and visitors to that address.

The Ombudsman considered the information available to him and identified an opportunity for a possible resolution to the complaint. He contacted the Housing Association and it agreed to:

- a) Write a letter outlining the options and actions that have already been considered/offered to regarding his complaint about his neighbour within 20 working days.
- b) offer him the use of noise recording equipment and invite him to confirm in writing that he is happy to accept this. The recording equipment should be installed within 10 working days of receipt of his confirmation of his willingness to proceed.

The Ombudsman considers that this is to be a reasonable means of achieving a resolution to Mr B's complaint.

Powys County Council – Repairs and maintenance (inc. dampness/ improvements and alterations e.g. central heating, double glazing)

Case number: 201801250 – Report issued in June 2018

Ms X complained that the inspector, on behalf of Powys County Council ("the Council") had failed to attend nine home visits to carry out an annual gas safety check.

The Ombudsman found maladministration on the part of the Council for failing in its responsibility to ensure the annual check was carried out on time.

The Council has therefore agreed to undertake the following actions:

- a) Apologise to Ms X for the delay in undertaking the inspection.
- b) Ensure the inspection is carried out within the next four weeks.
- c) Offer £125 to Ms X in recognition of its failure to undertake the inspection.

Planning and Building Control

Not Upheld

Ceredigion County Council – Unauthorised Development – Calls for enforcement action

Case Number: 201701912 – Report issued in April 2018

Mr Y complained that Ceredigion County Council (“the Council”) had not taken sufficient action in relation to an air ventilation system which had been installed at a printing works (“the Printing Works”) without the necessary planning permission. Mr Y said that it was not adequately soundproofed and as a result, it caused unbearable noise at his home.

The investigation considered what action the Council could have taken between 2 June 2016, when the Enforcement Team became aware of Mr Y’s complaint, and 22 June 2016, when the four-year period during which the Council could take any enforcement action expired. The Ombudsman found that the action of the Enforcement Team in establishing whether or not a breach of planning control had taken place was appropriate. He said that it was reasonable the Council was unable to start the enforcement process prior to 22 June 2016. The Ombudsman found that the actions of the Council did not amount to maladministration and the complaint was not upheld.

Early Resolution and Voluntary Settlement

Pembrokeshire County Council - Handling of planning application (other)

Case Number: 201707119 – Report issued May 2018

Mrs A made a complaint against Pembrokeshire County Council (“the Council”) about the activities being carried out at a scrapyards close to her property. She said a condition relating to the height of the scrap, attached to the planning permission, had not been enforced. She also said no effective action was being taken in relation to vehicles which were being parked on Council owned land, adjacent to the scrapyards. Finally, Mrs A complained she had not received a formal response to her complaints.

Although the Ombudsman considered that some of the matters were out of time for consideration, he was concerned about the complaints handling and that Mrs A did not appear to be aware of the action which the Council had been taking and its ongoing investigations. Because of this, he contacted the Council and it agreed to carry out the following:

- a) Provide an apology for the way the complaint(s) were handled and for any confusion this may have caused.
- b) Consider its complaints handling in light of the issues which had been highlighted.
- c) Provide Mrs A with a full response to the issues she had raised in accordance with its Complaints Policy.
- d) Write to Mrs A, fully setting out the action(s) which it has already taken and/or is currently taking in relation to the height of the scrap and the parking of vehicles on its land.
- e) Inform Mrs A of the outcome(s) of its investigation(s) in due course.

Pembrokeshire County Council – Handling of planning application (other)

Case Number: 201800027 – Report issued May 2018

Mr Y complained that Pembrokeshire County Council (“the Council”) had failed to take enforcement action against a developer who had breached conditions of a planning application granted for a camp site for static and touring caravans. He also complained that the Council had failed to communicate with him and deal with his complaint under its complaints procedure.

The Ombudsman found that there were apparent failings by it and contacted the Council. It agreed to the following as an early resolution to his complaint.

- a) Write a letter to Mr Y apologising for the delay in dealing with his complaint under its complaints procedure.
- b) Provide him with a written response at stage 2 of its complaints procedure to include what actions it has taken to date.

This will be completed within 30 working days of the date of this letter and the Ombudsman is satisfied that this will resolve his complaint.

Ceredigion County Council – Handling of planning application (other)

Case number: 201800472 – Report issued in June 2018

Ms A complained about the way Ceredigion County Council (“the Council”) approved a neighbour’s planning application in respect of a storage shed for plant and maintenance activities. She said it ignored her concerns and emails, and her formal complaint. Ms A also said the application was approved by an elected member with a conflict of interest.

Although the Ombudsman declined to investigate Ms A’s complaint, he recognised that the Council had provided Ms A with explanations about the planning process and whether her views were considered, and an apology for failing to acknowledge her emails. However, it appears it also failed to acknowledge her formal complaint. Because of this, he contacted the Council and it agreed to do the following within one month of the date of this decision

- a) To provide Ms A with a clear written explanation about why her formal complaint was not acknowledged, and an apology.

Roads and Transport

Early Resolution and Voluntary Resolution

Newport City Council – Transport Services

Case Number: 201707487 – Report issued in April 2018

Mr T complained that the Council had failed to respond to his and Bus Users Cymru's ("BUC") requests for an update on progress to re-commission/repair the Real Time Passenger Information ("the RTPI") system at his local bus stop.

The Ombudsman found that the Council had not responded to requests by BUC since October 2017. The Council was contacted, and it agreed to write a letter to Mr T which would:

- a) Provide an explanation of the current situation with regards to the RTPI at your local bus stop along with any proposed timetable for intended works, if applicable.
- b) Provide an apology for the lack of communication since October 2017.

This will be completed within 20 working days of the date of this letter. The Ombudsman is satisfied that the agreed actions will provide an early resolution to his complaint.

Cardiff County Council – Other

Case number: 201801111 – Report issued in June 2018

Mrs X complained that Cardiff County Council ("the Council") failed to consider a complaint about a breach of Health and Safety ("H&S") regulations by a neighbouring public house ("the pub").

The Council originally dealt with Mrs X's concern as a request for a Traffic Regulation Order, as it related to the use of a lane to make deliveries to the pub. The Ombudsman considered that the Council's interpretation of Mrs X's concerns was understandable.

However, Mrs X subsequently clarified her complaint and, following enquiries by the Ombudsman, conceded that Mrs X's concerns should have been passed on to Shared Regulatory Services ("SRS") as it is responsible for investigating H&S breaches in the pub and anywhere within its curtilage.

The Council therefore agreed to complete the following actions by 9 August 2018 in settlement of Mrs X's complaint:

- a) Apologise to Mrs X for not passing her original contact onto SRS to be considered as a H&S concern.
- b) Explain why Mrs X's previous contact had not been passed onto SRS.
- c) SRS to visit the pub to discuss the H&S concerns.
- d) Install a taller bollard at the location which is more visible to drivers using the lane.

Social Services - Adult

Early Resolution and Voluntary Settlement

Newport City Council – Services for vulnerable adults (e.g. with learning difficulties or mental health issues)
Case number: 201708075 – Report issued in June 2018

Mrs A complained that the service provided to her adult son, B, by the adult social services department of Newport City Council (“the Council”) was not reasonable or appropriate. Mrs A made a number of complaints about the services which had or had not been provided to B, his eligibility for services, and her involvement and interactions with the adult social services department.

The Ombudsman noted that Mrs A’s complaint had not been considered at each of the stages set out in the Council’s Complaints Procedure. As a result, the Ombudsman contacted the Council who agreed to do the following:

- a) To appoint an Independent Investigator to complete an investigation into the complaint in line with Stage 2 of the Council’s Complaints Procedure.
- b) To offer Mrs A and her family a payment of £50 for the time and trouble they had been caused in bringing their complaint to the Ombudsman.

Carmarthenshire County Council – Social care assessment
Case number: 201700171 – Report issued in June 2018

Mr A’s complained about Carmarthenshire County Council’s (“the Council”) response to his Stage 2 complaint investigation. This included the Council not detailing the measures it had put in place to address the identified failings around assessments, statutory and non-statutory services and eligibility.

The Council acknowledged shortcomings in its complaint handling and agreed to take the following actions:

- a) apologise to Mr A for the failings identified and pay him the sum of £250 for the time and trouble caused to him in pursuing his complaint.
- b) revise its Complaint Process flowchart so it meets the requirement of the Welsh Government’s guidance on complaint handling and representations by local authority social services (2014).
- c) provide evidence of the training programme it has drawn up in relation to complaint handling.
- d) provide an explanation of the Eligibility Criteria for the Transition Team and update the details displayed on its website accordingly.
- e) provide the Ombudsman with copies of the revised policies, accompanied by an action plan, which should include appropriate timescales for ensuring implementation and monitoring of compliance.

Social Services – Children

Upheld

Vale of Glamorgan Council – Children in care/taken into care/'at risk' register/child abuse/custody of children
Case Number: 201606901 – Report issued in April 2018

Mr X complained about the service provided to his daughter, Q, by the Vale of Glamorgan Council ("the Council"). Mr X complained that, between April and December 2015, the Council failed both to appropriately assess Q's needs, as a child under the age of 18, and to provide appropriate support and intervention. Mr X complained that the lack support affected Q's wellbeing and her ability to parent her new-born son, Child Z. Mr X said that this ultimately lead to Child Z being taken away from Q and adopted.

The Ombudsman found that Q presented a significant challenge to the Council, as she declined services and did not fully engage with the Council's attempts to assist her. He found that the Council could not compel Q to accept assistance and was required to respect her wishes, even if the decisions she took appeared unwise.

However, the Ombudsman concluded that there was an unnecessary delay in Q's needs being assessed and upheld that element of the complaint. The Ombudsman found that, as a result of the lack of a needs assessment, the support and intervention provided to Q lacked adequate direction and did not have the benefit of clearly defined expectations and desired outcomes. Consequently, to this limited extent, he upheld that element of the complaint.

The Ombudsman recommended that the Council should apologise to Q and Mr X for these failings and take action to address the administrative shortcomings identified.

Gwynedd Council – Other

Case Number: 201700072 – Report issued in April 2018

Mr X submitted a complaint about Gwynedd Council's Social Services Department ("the Council") raising the following concerns:

- a) The Council failed to provide Mr X's step son, Mr Y, with adequate services, between 2010 and 2016 and that it considered discontinuing the services offered to Mr Y, without conducting an assessment of his needs.
- b) The Council failed to handle Mr X's complaint in accordance with the Complaints Procedure for social services complaints.

The investigation found that the Council failed to assess the needs of Mr Y and his family following the outcome of a Stage Two investigation in 2010.

It also found that a number of opportunities to fully assess Mr Y's needs were later missed. The complaint was upheld as, in the absence of a comprehensive assessment, the Ombudsman could not be satisfied that Mr Y was in receipt of adequate services.

In relation to the second complaint, the Ombudsman found that the Council failed to correctly apply the relevant Regulations and consequently unreasonably denied Mr X the opportunity for his complaint to be considered at Stage Two of the Complaints Procedure for social services complaints.

A number of recommendations were made, including an apology and financial redress.

Not Upheld

[Powys County Council - Children in care/ taken into care/ 'at risk' register/ child abuse/ custody of children](#)

[Case Number: 201703262 – Report issued in April 2018](#)

Mr X made a complaint against Powys County Council (“the Council”) that his son was subject of a child protection enquiry which was not undertaken in accordance with the All Wales Child Protection Procedures (“the AWCPP”). He complained that he was not advised that enquiries were being undertaken and that his son, Y, was removed from class and interviewed without his knowledge. He also complained that he was then visited at home by a social worker and a representative of the Education Department

The Ombudsman found that the Council’s decision to interview Y, without first seeking Mr X’s consent, was appropriate and that the enquiries had, in the main, been undertaken in accordance with the AWCPP. The Ombudsman did not uphold the complaint.

[Conwy County Borough Council – Other](#)

[Case Number: 201700406 – Report issued in May 2018](#)

Mrs R complained about the actions of the Council and Betsi Cadwaladr University Health Board (“the Health Board”) in relation to child protection concerns regarding her granddaughter, A, following a report by A’s father that, during a contact visit, he had observed bruising to her leg. Mrs R also complained about the investigation of her complaint, and its outcome.

The Ombudsman found that the Council’s actions were reasonable, in view of the evidence it had at the time, and the independent investigator’s report into Mrs R’s complaint was thorough and its conclusions were reasonable. He did not uphold the complaint against the Council.

The Ombudsman also found that the actions of the Health Board’s hospital staff were reasonable and did not uphold that part of the complaint. However, the Health Board had not handled Mrs R’s complaint appropriately, and he upheld this part of the complaint. The Health Board agreed to apologise to Mrs R for this failing.

Early Resolution and Voluntary Settlement

[Carmarthenshire County Council – Children in care/ taken into care/ 'at risk' register/ child abuse/ custody of children](#)

[Case Number: 201706555 – Report issued in April 2018](#)

Ms A complained about the Social Services Team at Carmarthenshire County Council (“the Council”) and, in particular, a lack of care towards her daughter’s safety when using social media. Ms A also raised concerns over a lack of communication and the fact that she had not received a formal response to her concerns.

The Ombudsman found that although Ms A has not been through the Council’s complaint procedure, the Council should have noted her dissatisfaction from her correspondence and dealt with Ms A’s concerns as a formal complaint.

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

- a) Within 28 days from the date of the Ombudsman’s decision, arrange a meeting between Ms A, her daughter and the Social Services Team.
- b) Within one month from the date of the meeting, issue a Stage 1 written response to the complaint.

Powys County Council – Children in care/ taken into care/ 'at risk' register/ child abuse/ custody
Case number: 201707559 – Report issued in June 2018

Miss A complained about the assessment, review, safeguarding and contract monitoring functions of Powys County Council's Social Services department ("the Council"). Specifically, Miss A complained that she was not given review and report documentation in respect of her child and that the Council failed to gather relevant medical information. Miss A also complained that concerns raised about the care being provided to her child as a Looked After Child were not considered.

The Ombudsman identified that Miss A's complaints had not been fully considered by the Council in accordance with the Social Services Complaints Procedures (Wales) Regulations 2014 ("the Procedure").

The Council therefore take Miss A's concerns further to investigate and respond to Miss A according to the Procedure.

Caerphilly County Borough Council – Other
Case number: 201707883 – Report issued in June 2018

Mrs A complained that Caerphilly County Borough Council's social services department ("the Council") failed to act on a risk referral from a GP in relation to her grandchild in April 2015. Mrs A having recently become aware that such a referral was made complained to the Council in March 2018.

The Ombudsman ascertained that although the Council had received Mrs A email expressing concern about this referral it had not been acknowledged, considered or responded to. This failing was in part due to the Council's consideration of Mrs A's recurrent and repetitive complaints relating to historic complaints relating to the service.

Whilst the circumstances provided some explanation for the Council's omission to consider this matter under the relevant complaints process, the Ombudsman took the view that this was in effect a "new" matter, Mrs A having recently become aware of it, and so the Council should now investigate and respond to it.

The Council agreed to investigate the "new" matter and respond to the complaint in line with the relevant procedure.

Various Other

Early Resolution and Voluntary Settlement

Cwm Taf University Health Board – Rudeness/ inconsiderate behaviour/ staff attitude

Case Number: 201707860 – Report issued May 2018

Mr B complained that a nurse employed by Cwm Taf University Health Board (“the Health Board”) had disclosed personal information about him to others on a ward. That disclosure had since caused him significant distress and anxiety, as well as resulting in a loss of sleep and an inability to perform some daily tasks without help (which he paid for).

Mr B said that the staff member’s actions had impacted adversely on his health and quality of life, as well as his losing confidence in the hospital which he would have to regularly attend because of his own health issues. Whilst the Health Board had apologised to Mr B for the disclosure, he was unhappy as he wanted financial compensation.

The Ombudsman declined to investigate the complaint, as the remedy of legal action was reasonably available to Mr B to pursue any claim for compensation, should he wish. Nevertheless, it was noted that despite Mr B’s complaint letter alleging that the staff member’s actions had caused him harm, the Health Board had not addressed this point in its response. This was specifically required and provided for within PTR1, and the Ombudsman usually expected a health board to address this question before he would consider any complaint. The Health Board agreed to undertake the following action in resolution of the complaint:

- a) Fully consider Mr B’s complaint again and issue him with a PTR compliant response, addressing the allegation of harm, within 6 weeks.

Cardiff County Council – Other miscellaneous

Case number: 201800502 – Report issued in June 2018

Ms X complained that Cardiff County Council (“the Council”) failed to take into account that she could not afford to pay a fine within three months.

After carefully considering the complaint the Ombudsman has found some element of maladministration on the part of the Council in determining whether or not Ms X could reasonable afford the requested payments.

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

- a) Consider the income/expenditure position in full.
- b) Consider the circumstances and reach a view on what is genuinely affordable.
- c) Apologise for providing inaccurate information with regards to the maximum period in which payments can be made.

Aneurin Bevan University Health Board – Poor/ no communication or failure to provide information

Case number: 201800392 – Report issued in June 2018

Mr and Mrs A complained about delays on the part of Aneurin Bevan University Health Board (“the Health Board”) in the set-up of a new day service unit for their adult child with complex care needs. The opening of the unit was delayed for a significant period during which time they had agreed to the provision of reduced care services for their child. During this period services were disrupted further when the transport

for their child unexpectedly required repairs. Although the Health Board offered alternative ways to provide the reduced level of service to Mr and Mrs A's child these were not considered to be suitable or in their best interests.

Whilst noting that Mr and Mrs A agreed initially to the reduction of services and declined the offers made when transport became unavailable, the Ombudsman noted that services had been disrupted for an extensive period beyond those anticipated. In consequence Mr and Mrs A's child did not receive the services set out in the care plan during this extended period or at all whilst waiting for the transport to be repaired.

In recognition agreed to Health Board:

- a) Provide a letter explaining the nature of and reasons for the delays encountered.
- b) Acknowledge the loss of service experienced during the period when transport was unavailable.
- c) Make a time and trouble payment in the sum of £250.