

The Ombudsman's Casebook

Issue 31 January 2018

News

Public Services Ombudsman (Wales) Bill

The Ombudsman Bill continues to progress through the legislative process. Oral scrutiny sessions with a range of stakeholders were conducted by the Assembly's Equality, Local Government and Communities Committee and the committee will now produce a report.

For further information on the bill please visit [here](#) and for the legislative timetable please visit [here](#).



Ombudsman Praised For Prudent Approach

In November, the Ombudsman and senior colleagues appeared in front of the Assembly Finance Committee to give evidence on the 2018/19 budget forecast.

The Finance Committee reported positively on the budget submission, welcoming the "prudent approach" and the focus on improvement work.

The Ombudsman said he was delighted that the committee had recognised the office's innovative way of working which included the use of new technology and putting the emphasis on public bodies to settle complaints sooner themselves.

Health Sounding Board

In November, we hosted the third meeting of the Health Sounding Board.

The group discussed how PSOW shares examples of best practice to encourage learning between bodies. It is hoped that the new All-Wales complaint handling networks will contribute towards identifying best practice.

The group also discussed the quality processes PSOW uses during recruitment of staff; the casework process and its quality assurance.

Finally, the group was updated on how PSOW will send sensitive information going forward, reflecting its continued focus on information security and the new GDP Regulations.

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Casebook in numbers

These infographics illustrate the cases closed between October and December 2017 by subject and outcome. They do not include enquiries or complaints deemed premature (where public bodies have not been given the opportunity to resolve a complaint locally) or out of jurisdiction. Please note the early resolutions category also includes voluntary settlements.

Health	76
Complaint Handling	19
Adult Social Services	10
Planning & Building Control	6
Housing	5
Children's Social Services	5
Environment & Environmental Health	4
Roads & Transport	4
Various other	3
Finance & Taxation	1
Self-funding care provider	1
Education	1
Benefits Administration	1



2



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21



73

● Public Interest ● Upheld ● Not Upheld ● Early Resolution

What's in the postbag?

Increasingly Welsh public bodies are delivering services through arrangements with third parties. These can include partnership agreements with other public bodies, services commissioned from the private sector, arm's length or wholly owned companies or charitable trusts.

The experience of cases coming to this office is that such arrangements can blur the lines of accountability making it difficult for service users to know who they should complain to.

Regardless of how services are delivered, the public body with the statutory responsibility to deliver the services remains accountable for that service. When such complaints are made to the Ombudsman he will consider any complaint in the usual way and hold the public body with overall responsibility for the service to account for the delivery of the service.

Complaints processes must therefore be clear and simple for members of the public to follow. The Ombudsman expects public bodies entering into arrangements with other public bodies or third parties to ensure that it has robust governance arrangements in place.

Governance arrangements

- Public bodies must include clear arrangements for complaint handling in any contract or agreement with partner organisations.
- Any such arrangements must be consistent with any statutory complaints process (e.g. Putting Things Right /Children's Social Services complaints) and should otherwise follow the [Model Complaints & Concerns Policy](#).
- The arrangements must be clear about how disputes between the public body and the provider are dealt with to ensure they do not impact upon the process for responding to the complainant.
- Be clear in the arrangements about which party to any agreement is responsible for responding to a complaint.
- If a partner organisation is responsible for responding to a complaint on behalf of the public body, ensure that the partner organisation informs the complainant of their right to complain to my office.¹
- Ensure staff within all organisations know what the arrangements are and what their role is in carrying them out.
- Ensure that the public body with overall responsibility for the service is informed about all complaints and monitors the outcomes of complaints.
- Ensure that elected councillors and independent board members understand complaint mechanisms so that they can respond to queries from the public.

The Ombudsman welcomes the fact that public bodies are collaborating and working jointly with the aim of providing streamlined services to the public. However, when failings are made it is important that members of the public have the same access to justice.

The Equality, Local Government and Communities Committee of the Assembly's consideration of the PSOW Bill is ongoing. The Ombudsman very much hopes it will decide to progress the Bill. Should the Com-

1 In compliance with Section 33 PSOW Act 2005



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plaints Standards Authority function within the Bill be enacted, this office would be able to monitor public bodies handling of complaints where such arrangements have been made across Wales so that performance data can be monitored. This should help ensure a more citizen-centred service in Wales.

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 201604287 – Report issued in October 2017

Ms D complained about the care and treatment that her late father, Mr F, received at Prince Philip Hospital when, on the day that he was due to be discharged following a hip replacement operation, he rapidly deteriorated, suffered a cardiac arrest and, sadly, died. Ms D complained that clinicians were slow to respond to Mr F's deterioration and, consequently, any opportunity there may have been to stabilise his condition was lost. Ms D also complained that clinicians failed to advise the family of Mr F's poor prognosis and subsequently failed to provide the family with a clear explanation of the cause of Mr F's deterioration and death. Finally, Ms D complained that the Health Board's handling of her complaint about these matters was unnecessarily protracted and added to the family's distress.

The Ombudsman, assisted by his Clinical Advisers, upheld Ms D's complaints. He found that an incomplete provisional diagnosis of Mr F's condition was made by two junior doctors who were inadequately supported by senior physicians. The junior doctors failed to identify that Mr F was in cardiac failure. Whilst it was not possible to say that this directly led to Mr F's death (given his comorbidities and poor prognosis), the Ombudsman considered that the uncertainty surrounding this matter amounts to a significant injustice to the family. The Ombudsman also found that, as a result of this initial failing, the family was not accurately advised of Mr F's poor prognosis or, subsequently, of the precise cause of his death. Finally, the Ombudsman found that there were substantial delays in the Health Board responding to the family's complaint. The Ombudsman recommended that:

- a) The Health Board provides Ms D with a fulsome written apology for the identified failings, and, in recognition of the distress and injustice caused to the family, makes a payment to them of £2,500 plus £250 for its poor complaint handling.
- b) The Health Board produces a detailed, written escalation policy and makes this available to medical and surgical clinicians of all grades at Prince Philip Hospital.
- c) The Health Board demonstrates that it has reminded physicians (particularly consultants) working in the Trauma & Orthopaedic Department, of the requirement to conduct and record a daily, documented review of patients in accordance with guidance issued by the Academy of Medical Royal Colleges and by the Royal College of Physicians.
- d) The Health Board demonstrates that it has reminded all middle-grade and senior doctors at Prince Philip Hospital of their obligation to adequately support and supervise junior doctors in accordance with General Medical Council and other guidance.
- e) The Health Board urgently reviews its pre-operative assessment protocol to ensure that patients with cardiac risk-factors are identified and receive an appropriate, documented, clinical management plan in advance of any surgery.
- f) The Health Board demonstrates that it has taken steps to ensure that clinicians at Prince Philip Hospital are made aware of the role of, and means of liaising with, the Medical Emergency Team in responding to critically ill patients.
- g) The Health Board reminds Trauma and Orthopaedic Nurses at Prince Philip Hospital that it is good practice to conduct physiological observations on patients on the day of their discharge.

- h) The Health Board reminds the Concerns Team of the need to comply with timescales set out in Putting Things Right regulations and to provide explanations to complainants of unforeseen delays in the production of responses.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case number 201605326 - Report issued in October 2017

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

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

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

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

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

- a) Undertake a NEWS (National Early Warning Score) audit. This should include a minimum 10% dip sample of the NEWS recorded on the ward in the past three months. If members of staff involved in the recording of NEWS for Mr D are now working in a different area, the audit should also include a sample of their current practice. If anomalies are identified, an action plan should be prepared to put this right.
- b) Share this report with the nursing staff involved in this case. Those members of staff should be given training on NEWS and escalation procedures.
- c) Ensure that there is a robust handover system in place and that all acutely ill patients undergo a daily review by a registrar (or above), including on weekends and holidays.

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- d) Share this report with the doctors involved in this case. The doctors should then review the report and medical notes with their appraiser to identify areas where practice could be improved.
- e) Discuss this case with the Coroner and based on that discussion undertake an audit (minimum 10% dip sample) of coroner referral forms for the past three months. If inconsistencies or inaccuracies are identified, an action plan should be prepared to address them, this may include introducing a review system or additional training for doctors preparing the forms.
- f) The Head of Corporate Governance should review the complaint handling in this case. The review should seek to identify what happened to the Serious Incident Report.

g) Apologise to Ms C and her family for the failings identified in this report. A meeting with the Chief Executive or the Medical and Nursing Director should be offered to Ms C.

h) Make a payment to Ms C of £10,000 in recognition of the distress and uncertainty caused by the clinical failings identified in this report. This payment is also in recognition of the time and trouble taken in pursuing this complaint, due to the complaint handling failings identified in this report.

UPHELD

Welsh Ambulance Services NHS Trust – Ambulance Services Case Number 201606950 – Report issued in October 2017

Mrs B complained about the care and treatment provided by the Welsh Ambulance Services NHS Trust ("WAST") to her mother Mrs C. Mrs C fell at home and Mrs B said WAST did not attempt to establish whether there had been a medical reason for the fall and failed to adequately immobilise her. She also complained that Mrs C, who also had a chest infection, had been kept in a cold ambulance without a clinical assessment.

The investigation found that WAST did not take the necessary steps to establish the reasons why Mrs C fell or to immobilise her. It was not possible to establish the temperature in the ambulance as this was not recorded but WAST failed to record any ongoing clinical assessments of Mrs C, while she waited in the ambulance to be admitted to hospital. These failings caused distress to the complainant. WAST agreed to:

- a) write to Mrs B and apologise for the failings identified in the report
- b) provide evidence to the Ombudsman that learning from this case has been shared; and
- c) undertake an audit to ensure that the staff members involved are now adequately recording clinical assessments and treatment decisions.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201604855 – Report issued in October 2017

Miss X complained about the care and treatment her late father, Mr Y, received from Cwm Taf University Health Board ("the Health Board"), between August and December 2015. In particular, Miss X raised the following concerns:

- The standard of general and oral hygiene care, as well as catheter care, provided to Mr Y, fell below a reasonable standard.
- Whilst a patient at Prince Charles Hospital, the management of Mr Y's Percutaneous Endoscopic Gastrostomy ("PEG") feeding tube fell below a reasonable standard and contributed to his death.

In relation to the first complaint, the Ombudsman found that the Health Board failed to treat Mr Y with dignity when attending to his nursing care needs and failed to tailor his care to his particular needs. Its failure to appropriately assess Mr Y affected his access to other services which he should have received. The Ombudsman also found that the standard of record keeping in relation to Mr Y's catheter care was poor and that, consequently, he was unable to determine whether Mr Y received an appropriate standard of catheter care. The complaint was upheld and a number of recommendations were made.

The Ombudsman was unable to reach a finding in relation to the second complaint as there was insufficient evidence available.

Cardiff and Vale University Health Board – Clinical treatment outside hospital

Case Number 201700272 – Report issued in October 2017

Mr L complained to the Ombudsman about the decision by a Community Mental Health Team (CMHT) managed by Cardiff and Vale University Health Board (“the Health Board”) not to allow him to receive secondary care services from the team. The Team considered that Mr L’s mental health issues could be managed by the Primary Mental Health Support Service (PMHSS).

The Ombudsman found that the Health Board’s decision not to admit Mr L to the care of the CMHT and to offer him support from the PMHSS was reasonable in keeping with Welsh Government regulations. However, the Ombudsman did consider that the Health Board had failed to evidence that it had provide Mr L with a sufficiently detailed explanation to explain why he was not considered eligible for services from the CMHT. He therefore upheld the complaint to this limited extent and recommended that the Health Board should:

- a) apologise to Mr L, and
- b) provide him with an explanation and specific reasons for its decision not to offer him CMHT support.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number 201606095 – Report issued in October 2017

Mrs B complained about a number of aspects the nursing care her late husband received whilst a hospital inpatient. These concerns included: a failure to place ‘nil by mouth’ (NBM) notice next to Mr B’s bed in A&E and that he was given tea and toast despite being NBM; failing to inform Mr B’s family in a timely manner that Mr B had contracted MRSA; the manner in which nursing staff gave a distressing letter to Mr B whilst he was very poorly, and that Mr B’s pressure sores and diabetic care were inadequate while in hospital.

The Ombudsman found that a nurse had made an entry in the notes that Mr B had been given tea and toast. He was satisfied however, on balance, based on the available evidence, that this had been an entry made in error. The Ombudsman was critical of the record keeping in this case and upheld the complaint on the basis of the distress that this mis-information had caused Mr B’s family. He also found that the manner in which staff had given Mr B two letters asking Mr B to consider finding alternative accommodation to be inappropriate. The Ombudsman found that Mr B’s pressure ulcer care may have been inadequate as there was insufficient evidence that staff had turned him appropriately early on in his admission. He upheld this aspect of the complaint. The Ombudsman did not uphold the complaints that related to Mr B’s diabetic care and the manner they managed his MRSA.

The Ombudsman recommended:

- a) redress totalling £1000 for the distress caused to Mr B’s family at being told that he had choked on tea and toast and for the possibility that poor pressure ulcer care may have led to him developing pressure sores; and
- b) that staff were reminded of the need to complete records accurately, to follow pressure sore guidelines and introduce guidelines to ensure patients are supported when potentially distressing correspondence is given.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number 201606885 – Report issued in October 2017

Mrs A complained that, when seeking consent to undertake cataract surgery, the clinicians failed to provide her with sufficient information, resulting in her being unable to make an informed decision about the risks associated with the surgery and, whether she wanted to proceed with the operation.

The investigation found that whilst there was an indication that cataract surgery was discussed with Mrs A on two occasions, there is no record of what had been discussed or that the clinician was satisfied that

Mrs A understood the general risks of surgery as well as the increased risks as a patient with Diabetes. The complaint was upheld.

It was recommended that Hywel Dda University Health Board ("the Health Board"):

- a) apologise to Mrs A
- b) pay her £250 for the time and trouble of bringing her complaint to this office
- c) remind Ophthalmic staff of the need to ensure that, when taking consent from a patient, support is provided to ensure that the patient fully understands the proposed treatment, the available options (including the option not to proceed) and the risks associated with the treatment. The content of these discussions with the patient should be documented

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201604658 – Report issued in October 2017

Ms D complained to the Ombudsman that, during a series of hospital admissions between September and December 2014, clinicians at Prince Phillip and Glangwili Hospitals failed to detect that her late father, Mr F, was suffering from a leaking aortic aneurysm that had been surgically repaired in 2013. Whilst the leak was eventually detected by clinicians, Ms D questioned whether the delay in identifying the problem contributed to her father's deterioration and death some two days after undergoing surgery to repair the leak.

Ms D also complained that Hywel Dda University Health Board's ("the Health Board") subsequent handling of her complaint about Mr F's care was unnecessarily protracted and added to the family's distress.

The Ombudsman, assisted by his Clinical Adviser, found no evidence that Mr F had displayed signs and symptoms of a leaking aneurysm that clinicians had failed to detect and was satisfied that Mr F's presenting medical conditions were appropriately investigated and treated.

However, the Ombudsman did find that there was an excessive delay in the Health Board's handling of Ms D's complaint.

The Ombudsman recommended that the Health Board:

- a) provide Ms D with a written apology for this delay and
- b) make a payment to her of £150 in recognition of how its poor complaint handling would have added to the family's distress.

The Health Board accepted the Ombudsman's findings and recommendation.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201604913 – Report issued in October 2017

Mrs X complained that her late husband's metastatic spinal cord compression ("MSCC") was not diagnosed, there was a lack of treatment for a sternum fracture and he was not monitored for 24 hours before Enzalutamide (hormone therapy for men whose cancer has spread and stopped responding to other hormone therapy) was stopped. Mrs X also complained about the care Mr X received at appointments between October 2014 and March 2015, and the Health Board's complaint handling.

The Ombudsman found that Mr X's symptoms were not suggestive of MSCC between July 2014 and 23 January 2015, Mr X's sternal fracture was confirmed by X-ray and his subsequent treatment was appropriate, and as Enzalutamide caused high blood pressure it was good practice to have stopped it. These aspects of the complaint were not upheld. The Ombudsman found that before 23 December 2014 there was no need to have referred Mr X for palliative radiotherapy, however there was a delay in Mr X's radiotherapy and he upheld this aspect of the complaint as it amounted to an injustice for Mr X. The Ombudsman found that Betsi Cadwaladr University Health Board's ("the Health Board") first complaint response was provided in a timely manner, but the second response was not. This amounted to maladministration. He also found

that there were inconsistencies between the first and second response regarding the sternum fracture. He found that this amounted to maladministration and partly upheld these aspects of the complaint. The Health Board agreed to implement the Ombudsman recommendations that:

- a) within one month of the final report it consider whether palliative radiotherapy during holiday periods should be reviewed, and
- b) apologise to Mrs X for the delay in its second response.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital Case Number 201603119 – Report issued in October 2017

Mrs X complained about Abertawe Bro Morgannwg University Health Board's ("the Health Board") ante-natal care, specifically, and in view of her medical history, the delay in providing her with Consultant led care, its management of her request for an elective caesarean section ("ELC"), and the prescription of codeine.

The investigation found that Mrs X's ELC request was managed appropriately and in accordance with relevant guidance.

Whilst Mrs X was provided with Consultant led care from the outset of her pregnancy and was seen by an Obstetric Team earlier than the Health Board's expected timeframe, there was a delay in the Obstetric Team's management of Mrs X's headache symptoms which should have been optimised earlier. To this limited extent Mrs X's complaint was partly upheld. Appropriate recommendations were accepted by the Health Board and included:

- a) an apology for the limited shortcoming identified, and
- b) a review of its obstetric booking appointment system and cross site communications to ensure each is fit for purpose or where appropriate to make changes.

It was not possible to reach a finding on whether Mrs X was informed of the risks associated with taking codeine during pregnancy due to the limited content of the consultation note and the differing views of the Health Board and Mrs X. However, the codeine assisted Mrs X to tolerate her headaches and there was no clinical harm caused to Mrs X or her unborn child.

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201603014 – Report issued in October 2017

Mr Y complained that Cwm Taf University Health Board ("the Health Board") had prescribed Mr X the incorrect lower dose of anticoagulant medication, as bridging therapy, for surgery to remove a ureteric stent. Mr Y considered that had Mr X been prescribed the correct higher dose of anticoagulant his post-operative stroke could have been avoided.

The investigation found that Mr X was incorrectly prescribed the lower dose of anticoagulant based on the Health Board's Bridging Policy and Mr X's pre-operative CHADS assessment score. Further, no written evidence was found for the Health Board's rationale for its divergence from the Policy.

It was concluded that Mr X would have been at lower risk of stroke had he been prescribed the higher dose of anticoagulant for his surgery. However, it was not possible to definitively conclude that Mr X's post-operative stroke could have been avoided had he received the higher dose, albeit, it was concluded that this failure might have been a contributing factor. This caused uncertainty as to whether Mr X's outcome might have been different had he received the higher dose, and the continued distress to Mr X and Mr Y caused by this uncertainty amounted to an injustice. To that limited extent Mr Y's complaint was partly upheld. The Health Board agreed to implement the recommendations in the report which included:

- a) an apology and financial redress due to the uncertainty caused, and
- b) sharing the report with clinicians involved in Mr X's care, firstly to allow them to reflect on the findings, and secondly to remind them of the importance of detailing in a patient's records the ratio-

nale for any deviation from recommended guidelines.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201604371 – Report issued in October 2017

Mrs B complained about the standard of care and treatment provided to her late mother, Mrs C, at Morriston Hospital when she was admitted with sepsis. She was concerned that sepsis was not recognised early enough or treated with appropriate antibiotics. Mrs C sadly died the following day.

The Ombudsman found that Mrs C's sepsis was recognised promptly on admission and treated appropriately. He did not uphold this aspect of the complaint. There was a query as to whether a further medical review should have taken place following Mrs C's transfer onto the ward and the Ombudsman partly upheld the complaint to that limited extent. However it was very unlikely that an additional medical review at this stage would have had any bearing on the overall outcome.

Cwm Taf University Health Board - Other Case Number 201504889 – Report issued in October 2017

Mrs A complained about the standard of care and treatment provided to her daughter, B, by the Child and Adolescent Mental Health Services ("CAMHS") Team. Specifically, she complained that, on numerous occasions:

- There was a lack of proper assessment of B's needs and provision of appropriate support;
- B was discharged from the care of CAMHS despite ongoing issues and without referral for further support or assessment;
- B was not referred for assessment for Autistic Spectrum Disorder ("ASD") at an earlier stage.

The Ombudsman found that there was evidence that other health professionals had raised concerns in referral letters that there were some possible behavioural traits associated with ASD. However, the assessment following that referral did not address these issues properly. No referral for a neurodevelopmental assessment was made. The Ombudsman found that a referral should have been made. The timescales for assessment were also unacceptably long. A referral for neurodevelopmental assessment was finally made in February 2015 and this has yet to be concluded. The Ombudsman upheld the complaint.

He recommended that Cwm Taf University Health Board should:

- a) apologise to Mrs A and B;
- b) review B's current CAMHS provision (both progress of assessment and meeting any assessed needs)
- c) review and clarify the mechanism for referring children to the Neurodevelopmental Service in Cardiff.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201603464 – Report issued in October 2017

Mr A complained about the care and treatment his father, Mr B received during his admissions to Ysbyty Gwynedd and Llandudno General Hospital between May and August 2015. The investigation considered Mr B's complaints that there was a delay in diagnosing Mr B's bladder cancer and in receiving a urology procedure after being placed on the urology waiting list; that there was a delay in transferring Mr B to a hospice closer to his family, and that Mr B's reaction to his first blood transfusion was poorly managed.

The Ombudsman found that there was a delay in carrying out a procedure leading to a delay in definitively diagnosing Mr B's bladder cancer. This delay appeared to be as a result of consultant leave. Whilst carrying out the procedure earlier would not have materially altered the management plan and eventual outcome, the Ombudsman found that the delay would have caused anxiety to Mr A and the family as it

delayed a firm diagnosis. The Ombudsman upheld the complaint to this extent. He recommended Betsi Cadwaladr University Health Board ("the Health Board") should:

- a) apologise for these failings, and
- b) evaluate if the urology service is reliant on individual consultant urologists and to take action if necessary.

The Ombudsman found that the Health Board attempted to transfer Mr B in a timely way, including arranging funding for his transfer. He did not uphold this complaint. The Ombudsman found that the reaction to the first blood transfusion was managed appropriately and in line with relevant procedures. He did not uphold this complaint.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201604010 – Report issued in November 2017

Mr X complained that when he attended hospital with concerns that he was having a heart attack, the clinicians failed to take his concerns seriously and treated him for gastric pain. Mr X also said that the Hospital did not carry out relevant tests to discount his symptoms as cardiac related. He said that the delayed diagnosis of a heart attack led to extensive damage to his heart and a slower recovery.

Mr X also said that clinicians failed to administer relevant medication and prescribed morphine prior to the diagnosis of a heart attack. He complained that the prescription of morphine had increased his likelihood of an additional heart attack and increased his risk of death.

The Ombudsman found that, whilst it could not be established whether clinicians took Mr X's concerns seriously, there was a missed opportunity to diagnose the heart attack earlier and treat Mr X appropriately. He further found that Mr X did not receive a relevant test which may have confirmed his symptoms as cardiac related and that he could have been administered with alternative medication to morphine.

It was recommended that Hywel Dda University Health Board:

- a) apologise to Mr X
- b) pay him £300 in recognition of the uncertainty and distress caused to him due to the delay in the diagnosis of a heart attack; and
- c) that the relevant doctors discuss this case in their next supervision session.

Abertawe Bro Morgannwg University Health Board - Appointments/admissions/discharges and transfer procedures

Case Number 201606416 - Report issued in November 2017

Mrs X complained to the Ombudsman on behalf of her husband, Mr X, about the length of time he had had to wait for a procedure to reduce the size of his enlarged prostate. She was of the view that her husband had to wait an unacceptably long period of time for his surgery given that he had already had one unsuccessful operation. She also considered that Abertawe Bro Morgannwg University Health Board ("the Health Board") had delayed carrying out tests unnecessarily and that questioned why some tests were necessary.

The Ombudsman found that whilst not having had the outcome of his eventual surgery compromised by the delay in treatment, Mr X will have experienced a prolonged period of disability and pain whilst waiting for the surgery. To the extent that Mr X should have been considered a clinical priority within the cohort of patients not deemed as suitable for "urgent" treatment (in as in the case of life threatening conditions such as cancer), the Ombudsman upheld the complaint. The Ombudsman did not uphold the complaint relating to the Health Board's management of investigations leading up to Mr X receiving the surgery.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr X; and

- b) formally reviews its provision of treatment to urology patients with a clinical need for 'early' treatment', who do not require 'urgent' treatment (such as patients with cancer).

Betsi Cadwaladr University Health Board - Other Case Number 201700661 - Report issued in November 2017

Mrs A complained about delays referring her to a gender identity clinic in 2015 by the Psychiatrist based within the Community Mental Health Team. She set out the impact the delays had had on her. In addition, she was dissatisfied with the way that Betsi Cadwaladr University Health Board ("the Health Board") had communicated with her about her complaint.

The Ombudsman's investigation established that the correct referral route had not been used initially and this had been the reason for the delay. The Ombudsman also identified shortcomings in the way that the Health Board had dealt with Mrs A's complaint.

The Ombudsman's recommendations included:

- a) the Health Board's Chief Executive apologising for the failings identified
- b) making a payment to Mrs A of £1,000 in recognition of the distress caused to her by the delayed referral and the shortcomings in complaint handling; and
- c) checking whether other transgender patients may have been similarly affected by failings in the referral process.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201605657 - Report issued in November 2017

Mr Y's advocate complained on his behalf about the care and treatment his wife, Mrs Y, received following an operation in June 2014 to repair a rectovaginal fistula (this is an abnormal communication between the rectum and vagina), specifically the treatment she received for the urinary incontinence she suffered following the surgery. Mrs Y found out at the beginning of 2014 that the cancer in her vagina had progressed.

The Ombudsman found that whilst the initial care and treatment provided at a follow up appointment was reasonable, the subsequent care was not. The Health Board failed to follow an intended plan of care on two occasions. Whilst, on balance, it is unlikely that effective treatment could have been provided to improve Mrs Y's symptoms in the limited timeframe, the Ombudsman found it would have been fairer on Mrs Y to have known of any treatment options and had the opportunity to consider them. The failure to follow up on agreed actions which may have led to earlier diagnosis and discussion about treatment caused Mrs Y considerable discomfort, distress and upset and compromised her dignity. The Ombudsman upheld Mr Y's complaint. He made some recommendations to the Health Board to address the failings, including an apology to Mr Y.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201606665 - Report issued in November 2017

Ms A complained about her late mother's treatment at Hywel Dda University Health Board ("the Health Board") in May 2016. Ms A said that the failure to take appropriate action to reduce the risk of her mother falling led her to sustain an injury from a fall. Ms A also complained that there was a failure to care for her mother's resulting wound after she fell.

The investigation found that the Health Board had comprehensive policies for fall prevention and management and appropriate action was taken to reduce the risk of Ms A's mother falling. The Investigation Officer was satisfied that assessments, considerations and intervention planning were in place to reduce the risk of Ms A's mother falling and her resulting wound was not as a result of any inappropriate action. This complaint was not upheld.

The investigation also found that the care of Ms A's mother's resulting wound was prompt and appropriate. The complaint about a failure to care for her mother's wound after the fall was nevertheless upheld due to the shortcomings found in the Health Board's consideration of her mother's capacity, consent process and communication with the family about her care and surgery. The Ombudsman recommended:

- a) an apology for the shortcomings identified
- b) that staff should be reminded about good communication about care; and
- c) training to ensure that patient capacity is appropriately assessed.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201605620 - Report issued in November 2017

Mrs X's mother Mrs Y suffers from vascular dementia. Mrs X complained that her mother had not been immediately catheterised on admission to Ysbyty Glan Clwyd on 22 December 2014, her mother's ward and bay changes worsened her mental state, she had to transfer her mother between hospitals and her mother's low blood pressure was not managed. Mrs X also complained about a lack of communication between hospitals and the family, and about the Health Board's complaints handling.

The Ombudsman found that Mrs Y's catheter insertion was appropriate, but that her observations were not conducted in a timely fashion. He found that Mrs Y's ward and bay changes were appropriate, but that it was inappropriate that Mrs X transferred her between hospitals. The Ombudsman found that Mrs Y's low blood pressure was not investigated and there was poor communication between hospitals and Mrs Y's family. The Ombudsman also found that the Health Board's complaint response to Mrs X's should have identified Mrs Y's observations were not carried out in a timely manner, and its second complaint response took longer than necessary and erroneously said that her heart was monitored on admission. The Health Board agreed to implement the Ombudsman's recommendations to:

- A) apologise to Mrs X
- B) remind A&E staff of the need for timely observations
- C) consider patients bed moves in line with the Kings Fund recommendation
- D) involve the family of dementia sufferers in transport arrangements and review its transfer document
- E) establish why its response had not identified observations taken on admission and its incorrect response about heart monitoring, and inform Mrs Y of the outcome.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201605066 - Report issued in November 2017

Mrs X complained about her husband Mr X's pain management at Glangwili Hospital in September 2014, that he developed pneumonia, and about his discharge.

The Ombudsman found that Mr X's pre-assessment before his operation had not shared his chest problem with the admitting ward, the relevant Consultant and Anaesthetist; which may have led to this procedure being delayed. The Ombudsman found that Mr X's pain management whilst on the ward postoperatively and before the involvement of the Acute Pain Team was poor. The Ombudsman found that it was possible, albeit by no means certain, that Mr X's pneumonia could have been avoided had the operation been delayed and his pain relief improved. The Ombudsman also found that Mr X's discharge letter had not mentioned his postoperative pneumonia or pain control problems that led to difficulties in obtaining repeat prescriptions. The Health Board agreed to implement the Ombudsman's recommendations to:

- a) apologise to Mr X
- b) make a redress payment of £750

- c) review and establish guidelines to determine the standards of its discharge letters
- d) confirm its policies for patients identified at pre-assessment as being at risk for anaesthesia and for patients with high pain score
- e) remind nursing staff that pain scores are correctly recorded; and
- f) provide evidence of adequate arrangements that patients are reviewed by a senior doctor every 24 hours.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201604906 - Report issued in November 2017

Mr A complained about the surgical care he received at Withybush General Hospital ("the Hospital") on 10 April 2013 when he underwent a total right hip replacement surgery and subsequently discovered that his right leg was longer than his left. He also complained about the delay in carrying out a total left hip replacement. Mr A said he was placed on the waiting list in September 2014, because of pain he was experiencing across the base of his spine but his replacement hip surgery did not take place until December 2015. Finally, Mr A complained about the Health Board's handling of his complaint.

The Ombudsman's investigation found that overall there were no shortcomings in the care provided when it came to the surgery carried out in 2013 and Mr A's subsequent pain management. The Ombudsman also concluded that whilst the wait for the second surgery was not ideal it did not affect Mr A's long-term prognosis. The Ombudsman did not uphold these aspects of Mr A's complaint.

The Ombudsman identified shortcomings in record keeping by the Orthopaedic Consultant who had failed to inform either Mr A or his GP about Mr A's pre-existing right leg lengthening. As the information was also not documented in Mr A's medical records it caused confusion when reference was made to it in the Health Board's complaint response to Mr A. The Ombudsman concluded that these administrative shortcomings amounted to maladministration and to that extent upheld this aspect of Mr A's complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201605377 - Report issued in November 2017

Ms D complained to the Ombudsman about the medical care and treatment that her late father, Mr F, received during a series of admissions to the Royal Gwent Hospital (RGH) in 2015. Specifically, Ms D complained that:

1. Mr F was admitted to RGH on 24 March but was discharged two days later despite receiving a diagnosis of renal failure.
2. There was an excessive delay in conducting a bladder biopsy and in diagnosing Mr F's condition of bladder cancer.
3. During Mr F's admissions, clinicians proposed a range of possible diagnoses, each with a different prognosis. The family found this confusing and distressing.
4. Clinicians failed to conduct an X-ray following a fall that Mr F suffered at RGH.
5. There was a failure to fully explain to the family that Mr F's bladder cancer was untreatable and that he had reached the stage of requiring palliative care. There was also confusion surrounding the signing of a DNAR form and a failure to communicate to Ms D that Mr F was suffering with sepsis.
6. There were excessive delays in the Health Board's handling of the family's complaint about Mr F's care.

The Ombudsman, assisted by his Clinical Adviser, upheld complaints 2, 3 and 6 and partially upheld complaints 4 and 5. He did not uphold complaint 1.

The Ombudsman found that the delay in performing Mr F's biopsy led to a delay in the initiation of his cancer treatment. In turn, this delay may have compromised Mr F's capacity to withstand surgery and may have increased his susceptibility to urosepsis. The Ombudsman concluded that, due to Mr F's comorbidities and poor prognosis, it was not possible to definitively say that earlier diagnosis would have increased his chances of survival. However, the uncertainty surrounding this matter constitutes a significant injustice to the family.

The Ombudsman also found that there were communication failings between clinicians and the family to the extent that family members did not feel that they were fully informed about Mr F's condition and poor prognosis.

The Ombudsman recommended that the Health Board:

- a) provide Ms D with a fulsome written apology for the clinical, communication and complainthandling failings identified in this report
- b) in recognition of the distress and injustice that these matters caused the family, make a total payment to Ms D of £1,750; and
- c) remind urology physicians at RGH are reminded of the need to promptly arrange and conduct biopsies in cases of suspected urinary tract malignancies.

The Health Board accepted these findings and agreed to implement these recommendations.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201605851 - Report issued in November 2017

Mr B complained that clinicians at the University Hospital of Wales failed to act on the results of a cancer surveillance scan that he underwent which indicated spinal cord compression and the spread of cancer to his spine. Mr B complained that the scan result was noted only when a nurse accessed his records during an outpatient appointment a month after the scan was conducted. Mr B complained that his condition therefore went undetected for a month and that the treatment he subsequently received might have been more effective had it commenced sooner.

The Ombudsman, assisted by his clinical adviser, found that the scan result was reported within the time-frame stipulated in clinical guidance (and was, in addition, faxed to the requesting physician by a radiologist). However, there was no record of the results being received and seen by any clinician before Mr B's outpatient appointment. The Ombudsman found that, whilst this delay did not result in any clinically adverse consequence for Mr B, there was a risk that his spinal cord compression might have deteriorated while he was awaiting his review appointment. The Ombudsman also found that this failing caused Mr B considerable anxiety at a time when he had received an acutely distressing diagnosis. To that extent, the Ombudsman upheld Mr B's complaint.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr B
- b) in recognition of his distress, make a payment to him of £500; and
- c) provide an update on its development of an email based, 'end-to-end' electronic system for reporting and acknowledging scan results.

The Health Board accepted the report's findings and agreed to implement these recommendations.

Aneurin Bevan University Health Board– Clinical treatment in hospital Case Number 201603603 - Report issued in November 2017

Ms X complained about the care and treatment her late daughter, Baby A, received at the Royal Gwent

Hospital. Ms X said that communication between clinicians and the family had been poor and that there had been a delay in assessing and monitoring Baby A. Ms X also complained about the decision to treat Baby A with CPAP and expressed concerns that Baby A had been over-medicated which caused renal failure that the clinicians failed to manage.

The investigation found that the communication between clinicians was reasonable. However there had been a failure to discuss with Ms X whether the facilities at the hospital's neonatal intensive care unit could meet Baby A's needs. The investigation also found no evidence of delay in assessing and monitoring Baby A and that the decision to place Baby A on CPAP was reasonable. Finally, the investigation found that, given her complex health needs, the type and level of medication administered to Baby A was necessary, however there was some concern that Baby A should have been transferred to the cardiac paediatric intensive care unit sooner. The complaint was partly upheld.

The Ombudsman recommended that the Health Board:

- a) apologised to Ms X.
- b) remind relevant clinicians that, when amending a birth plan, full and meaningful explanations should be provided to the mother.
- c) ensure the relevant clinicians discuss the Ombudsman's report during their next supervision sessions; and
- d) create guidance for clinicians on the transfer of babies to specialist units.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201607516 – Report issued in December 2017

Mr A complained about surgery that was performed following a workrelated injury to his right index finger. He said that the surgery was not properly carried out. Mr A also complained about Abertawe Bro Morgannwg University Health Board's ("the Health Board") poor handling of his complaint.

The Ombudsman's investigation concluded that overall the care provided to Mr A was reasonable and appropriate. The Ombudsman was also satisfied with the Health Board's handling of Mr A's complaint and therefore did not uphold these aspects of Mr A's complaint.

However, the Ombudsman did highlight that it is accepted good medical practice that consent for anything but the most basic procedures should ideally be carried out in advance of any procedure and not in the operating theatre as Mr A might not have had sufficient time to digest the information about the surgery. However, he noted that it was documented that Mr A wished to preserve his finger length as it was important for his employment. He concluded that Mr A was aware of the risks and was unable to say that Mr A's decision would have been any different, given that surgery was required to treat his injury. The Ombudsman concluded that the failing around consent was a service failure and to that limited extent only upheld Mr A's complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201602646 – Report issued in December 2017

The Ombudsman considered the concerns Mr and Mrs A raised about the mental health care for their adult son, Mr B. Sadly Mr B took his own life in 2015.

Areas of concern were:

- Aspects of the management of Mr B's care (in particular that he was managed within primary care services and not secondary care). This was partly upheld.
- Queries about diagnosis and medication. This was not upheld

- Availability of CBT (Cognitive Behavioural Therapy). This was upheld.

In reaching his conclusions, the Ombudsman sought professional clinical advice. The Adviser made a number of recommendations for consideration. Some of these are pertinent to all mental health services in Wales. The recommendations are summarised only briefly below; the full version is available in pages 43-45 of the report:

- 1) Improved documentation of suicidal risk assessment which is easily accessible on patient clinical records and, related to this, consideration of improved training for frontline staff on suicidal risk assessment;
- 2) Improved access to psychological treatments; not just CBT- based, but also 'solution-focused' and 'motivational' therapies. It was noted that this was a national issue;
- 3) Consideration of improved tracking of referrals within Local Primary Mental Health Support Services (LPMHSS);
- 4) Greater clarity on the threshold for access to secondary care; the boundary between primary care and secondary care services is unclear as defined by the Mental Health Measure, and there are many patients who lie on the wide boundary between the two. It may be helpful to have local guidance to assist staff with their decision-making on this issue;
- 5) Greater emphasis on the role of drug/alcohol advice and services;
- 6) Consideration of clear standards for communication with GPs and other referrers following assessments and out-patient appointments;
- 7) Consideration of ways in which joint working between GP practice staff and LPMHSS might be facilitated, in the spirit of the Mental Health Wales Measure.

Welsh Ambulance Services NHS Trust and St John Cymru-Wales – Ambulance Services Case Numbers 201606907 / 201607455 – Report issued in December 2017

Mrs A complained that when St John Cymru-Wales ("SJCW") provided her late mother, Mrs B, with patient transport services on behalf of Welsh Ambulance Services NHS Trust ("WAST") Mrs B sustained an injury to her legs. Mrs A also complained that both SJCW and WAST failed to respond to her complaint about this matter in accordance with the 'Putting Things Right' Regulations.

The investigation found that whilst neither organisation disputed that Mrs B had been injured during the transfer, SJCW had failed to recognise the additional measures that could have been implemented to protect Mrs B's legs. The investigation also found that the both parties failed to respond to Mrs A's complaint in accordance with the Regulations, with SJCW referring Mrs A to its insurers.

It was recommended that both parties:

- a) apologise to Mrs A and her family and review the service level agreement to ensure it fully reflects the Regulations and provide training to all relevant officers
- b) that WAST pay Mrs A £750 in recognition of the delays experienced in resolving her complaint and £250 for the time and trouble in bringing her complaint to this office
- c) that SJCW pay £500 in recognition of the delays experienced in resolving her complaint and £250 for the time and trouble in bringing her complaint to this office and finally
- d) that SJCW request that its insurers expedite Mrs A's claim and that it creates a process for supporting complainants in these circumstances to make insurance claims.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201607274 – Report issued in December 2017

Mr X complained about his late mother's ("Mrs A") cataract treatment, specifically that Aneurin Bevan University Health Board's ("the Health Board") consent process was inadequate and that it failed to perform cataract surgery appropriately. Mr X also said that the Health Board failed to manage his complaint.

The Ombudsman found that there was evidence to show that a consent form was completed but there was insufficient documentation to support that the consent obtained from Mrs A was adequate. The complaint was upheld to the limited extent that the Ombudsman could not be satisfied that Mrs A was suitably informed of the risks.

Fortunately, Mrs A's surgery was necessary and appropriately carried out with timely referrals made in respect of her care. This complaint was not upheld.

In respect of complaint handling, the Ombudsman found that Mr X's complaint was not managed appropriately and upheld the complaint.

The Ombudsman made recommendations in respect of:

- a) clinicians' discussions of risk during the consent process;
- b) nominal financial redress
- c) an apology, and
- d) internal action about complaint management. The Health Board agreed to implement these recommendations.

Cardiff and Vale University Health Board - Other Case Number 201607082 – Report issued in December 2017

Mrs A complained about the care and treatment she received from the maternity unit at the University Hospital of Wales. She also complained about Cardiff and Vale University Health Board's ("the Health Board") poor complaint handling which had included an inappropriate comment being made to her and her husband at a local resolution meeting.

The Ombudsman's investigation found that whilst there were some service failings these had not caused Mrs A an injustice. He concluded that Mrs A's management and care during her pregnancy was on the whole reasonable and appropriate. This aspect of Mrs A's complaint was not upheld.

The investigation identified that communication with Mrs A was broadly reasonable, although there were instances when communication was not as effective as it could have been (for example prior to her discharge home with the baby and her attendance at the obstetric assessment unit postnatally). In relation to Mrs A's concerns about complaint handling, overall, the Ombudsman considered that the Health Board had provided a detailed response to Mrs A's complaint and had acknowledged failings when they occurred. He was however, concerned that the comment made by the Health Board's Investigating Officer was open to being misconstrued and had indeed caused Mrs A offence. The Health Board was asked to reflect further on this and to consider whether there was a need for additional Equalities and Cultural Diversity training for staff in light of this complaint. The Ombudsman concluded that the failings identified amounted to maladministration and had caused Mrs A distress and he therefore upheld this aspect of Mrs A's complaint.

Amongst the recommendations the Ombudsman made was that the Health Board should

- a) apologise to Mr and Mrs A for the failings identified by his investigation, and
- b) that it should make a payment to Mrs A of £500 in recognition of the distress caused by shortcomings in communication and complaint handling.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201606332 – Report issued in December 2017

Mr X had a history of stroke, chronic kidney disease, blood circulation disorder, heart disease, congestive cardiac failure, an amputated right leg and he had a left leg prosthetic graft (a surgical procedure to redirect blood flow by reconnecting blood vessels). On 2 December 2015, Mr X suffered a stroke and was admitted to the University Hospital of Wales (“the First Hospital”). Mrs X complained that the seriousness of Mr X’s left leg circulation was not recognised. Mr X was transferred to the First Hospital and his left leg was amputated on 16 December. On 27 July 2016, Mr X was admitted to the First Hospital, he had suffered an extensive stroke and aspiration pneumonia (food or liquid breathed into the lungs). Mrs X complained that Mr X’s nasopharyngeal airway (“NPA” a tube inserted into a nostril to secure an open airway) and bleeding from his nose were not managed. On 29 July Mr Y, sadly died.

The Ombudsman found that on 15 December Mr X’s left leg graft had occluded (graft failure), he should have been transferred for immediate vascular assessment, there was a failure to diagnose critical ischaemia (insufficient blood reaching the foot) and the unavailability of a Doppler scan (which measures blood flow) was unacceptable. The Ombudsman also found that Mr X’s nursing notes had not recorded family concerns, general nursing entries and leg observations. The Ombudsman found that Mr X’s treatment in July had been appropriate.

Cardiff and Vale University Health Board (“the Health Board”) agreed to implement the Ombudsman’s recommendations to:

- a) apologise to Mrs X
- b) make a redress payment of £500
- c) review whether Doppler scanners should be placed on elderly infirm wards and whether a pathway of care for referral and assessment by vascular surgeons should developed; and
- d) ensure a chart to monitor neurovascular observations is easily available, to review the protocol when patients need a senior review outside a speciality and an offsite referral is needed.

Aneurin Bevan University Health Board and a GP Practice in the area of Aneurin Bevan University Health Board – Clinical treatment outside of hospital Case Number 201603139 / 201603149 – Report issued in December 2017

Mrs X complained about the care and treatment her late husband received from the GP Practice and Aneurin Bevan University Health Board (“the Health Board”). Specifically, Mrs X said that there had been a delay in the GP Practice identifying Mr X’s need for clinical investigations. With respect to the Health Board, Mrs X complained that Mr X’s discharge home had not been safe, that the syringe driver had been left in his arm for too long and that there had been a failure to follow the “Putting Things Right” complaints process.

The investigation found that as soon as there had been a clinical indication that Mr X required clinical investigations, the GP Practice referred Mr X to hospital.

The investigation also found that discrepancies in the record keeping of the Registrar in the Surgical Assessment Unit resulted in Mr X being referred for the wrong type of endoscopy. This resulted in opportunities to identify and treat Mr X’s pain being missed. Finally, the investigation found that the Health Board did not meet the requirements of the complaints process and, despite a specific request for comments by Mrs X, it failed to address the matters of qualifying liability and redress.

It was recommended that the Health Board:

- a) apologise to Mrs X
- b) pay her a total of £2660 in recognition of the costs incurred in funding private consultation and tests, the failings identified in the report and the time and trouble in bringing the complaint to this office; and
- c) discuss the content of this report with the Registrar during his next supervision session, and refer

him for additional training on record keeping.

NOT UPHELD

Cwm Taf University Health Board – Clinical treatment in hospital Case Number 201604126 – Report issued in October 2017

Mrs X complained about the care and treatment provided to her late husband, Mr X. She was aggrieved that there were unreasonable delays in operating on Mr X's cancers. Mrs X complained that there was a failure to identify the spread of cancer to Mr X's neck. Mrs X was aggrieved that there was a failure to adequately manage the pain caused by the spinal cord compression (a tumour pressing on the spinal cord). Mrs X complained that there was poor communication on the part of the staff involved in Mr X's care regarding the management of his cancers. Mrs X was aggrieved that she did not know what was happening about the nature/grading of the cancers.

The investigation found that, given the complexities of Mr X's case, the overall delay in operating on his cancers was not unreasonable. It found that the delay that occurred in identifying the spread of cancer to the neck was not as a result of unreasonable care. The investigation found that whilst the pain Mr X was suffering from was not effectively managed, that was not as a result of unreasonable care. These aspects of the complaint were, therefore, not upheld.

The investigation found that there was inadequate evidence that Cwm Taf University Health Board ("the Health Board") staff kept Mr X and his family informed of the progression of his disease. The Health Board had acknowledged that ordinarily he would have been allocated a Clinical Nurse Specialist to act as the Health Board's single point of contact but one had not been available at the time. The Health Board had also apologised for the perceived lack of information. This aspect of the complaint was partially upheld.

Abertawe Bro Morgannwg University Health Board – Appointments, admissions, discharges and transfer procedures

Case Number 201606417 – Report issued in October 2017

Miss X complained about the fertility and gynaecological treatment she received from Abertawe Bro Morgannwg University Health Board ("the Health Board"). In particular, she complained that the Health Board failed to correctly calculate its Referral to Treatment target ("RTT"), which caused a delay to her treatment and failed to effectively communicate the expected timescales of her receiving treatment to her.

The Ombudsman did not uphold the complaint. There was no evidence to suggest that her treatment had been unreasonably delayed by the Health Board and the Ombudsman was satisfied that Miss X was treated according to her clinical need and that allowances had been made, where possible, to expedite her treatment, in recognition of the potential time sensitivity in her case. The Ombudsman was satisfied that the advice provided to Miss X in respect of the expected timescales for receiving treatment was reasonable.

A GP practice in the area of Cwm Taf University Health Board – Clinical treatment outside hospital Case Number 201607811 – Report issued in October 2017

Mrs X complained that the GP practice failed to consider or treat the cause of her back pain and that as a result there was a delay in referring her for further treatment. Mrs X said she had suffered severe pain as a result and wanted her back discs removed to function properly. She also complained that the GP practice prescribed her with inappropriate nasal spray for her asthma which triggered an asthma attack.

The investigation found that Mrs X's chronic back problem was appropriately managed and treated with care, with timely referrals made. In Mrs X's case, performing surgery would in all likelihood have led to greater complications and the advice given to her was correct. The investigation also found that her examination and prescription for her nasal spray was reasonable and no other alternative was available. There was nothing to suggest that an asthma attack was caused by the nasal spray and side effects of it were

very rare. The complaints were not upheld.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201605871 – Report issued in October 2017

Mrs A complained about the care and treatment she received from the Physiotherapy Department at Barry Hospital in May 2016. She complained that the assessment carried out by the Physiotherapist caused damage to her knee affecting her ability to lead a “normal life”.

The Ombudsman’s investigation concluded that the Physiotherapist’s management of Mrs A’s care was reasonable and appropriate and therefore did not uphold Mrs A’s complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201607418 – Report issued in October 2017

Mr E complained about the overall care and treatment he received when he attended the Emergency Department at the Royal Gwent Hospital. In particular, he was unhappy that he was inappropriately discharged without proper evaluation or diagnosis. Mr E said that he was subsequently diagnosed with Guillain-Barré Syndrome two days later. Mr E was also unhappy with Aneurin Bevan University Health Board’s complaint response.

The Ombudsman found that an appropriate clinical assessment was carried out and appropriate blood tests were also conducted. As Guillain-Barré Syndrome was a rare condition, the Ombudsman concluded that it was reasonable that Mr E was not diagnosed based on his presenting symptoms at that time. The Ombudsman did not uphold the complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201606970 - Report issued in November 2017

Mrs B complained that prior to undergoing a surgical procedure to treat achalasia (a condition that causes problems with swallowing) she should have been better informed of what the procedure involved and of the potential risks of the surgery. Mrs B further complained that she was provided with insufficient information about the side effects following discharge.

The Ombudsman found that whilst the consent form for surgery suggested that everything was explained to Mrs B in terms of the procedure and associated risks, he was unable to determine whether Mrs B fully understood the nature of the surgery and associated risks. As such, he could not safely conclude that there had been a clear conversation about what the procedure involved and the risks of the procedure and that, as a result, consent was properly informed. He was therefore unable to reach a finding on this matter.

In relation to the side effects, there was no evidence that Mrs B had been provided with any information upon discharge. This was a service failure. However, in keeping with the advice contained in the information leaflet that Mrs B should have been given on the day of her discharge, she attended hospital when she became unwell. As such, the failure to provide this information did not lead to Mrs B suffering any injustice. Consequently, the Ombudsman did not uphold this complaint.

Betsi Cadwaladr University Health Board - Appointments/admissions/discharges and transfer procedures

Case Number 201606863 - Report issued in November 2017

Mr Y complained that he had to wait an inappropriate length of time for surgery to remove a ureteric stent (a thin tube inserted into the ureter to prevent or treat obstruction of the urine flow from the kidney) and about a delay in undergoing surgery to remove kidney stones.

The Ombudsman considered whether Mr Y had been treated according to his clinical urgency. There was no evidence to suggest that Mr Y’s condition would justify expediting his treatment ahead of others. The Ombudsman found that it was not clinically unreasonable for Mr Y to have waited to have the stent re-

moved and to receive treatment for kidney stones. As such, there was no evidence of service failure on the part of Betsi Cadwaladr University Health Board and the complaint was not upheld.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201605726 - Report issued in November 2017

Mrs P complained about the post-operative care and treatment that her late husband, Mr P, received at the University Hospital of Wales following a transhiatal oesophagectomy that he underwent in November 2014 and following further, revisional surgery that he underwent in September 2015. Specifically, Mrs P complained that:

A nasogastric tube that was not correctly sutured in place became dislodged following Mr P's operation on 19 November 2014. This contributed to the failure of the operation as Mr P's stomach was unable to drain properly.

It was inappropriate and potentially dangerous that Mr P was encouraged to cough on the day following his first operation. The pressures exerted by coughing may have damaged his internal suturing.

There was an unreasonable delay in transferring Mr P to the Cardiac Unit when, during his second admission in October 2015, he developed severe fluid retention. This delay may have damaged Mr P's internal organs.

Following detection of a leak in the surgically reconnected ends of the oesophagus, there was an unexplained four-day delay before emergency surgery was performed.

The Ombudsman, with the assistance of his Clinical Adviser, was unable to identify any evidence to support Mrs P's complaint that the care and treatment that her late husband received was deficient or fell below a reasonable standard. The Ombudsman found no evidence that the displacement of the nasogastric tube contributed to the failure of Mr P's operation and no evidence to suggest that it was inappropriate or potentially damaging for Mr P to be asked by a physiotherapist to cough to clear his lungs. The Ombudsman also found that there was no adverse consequence to any delay in transferring Mr P to the Cardiac Unit, and that there was no delay in conducting surgery to repair Mr P's anastomotic leak.

Consequently, the Ombudsman was unable to uphold any of Mrs P's complaints.

Betsi Cadwaladr University Health Board and a GP Practice in the Betsi Cadwaladr University Health Board area – Clinical treatment outside hospital

Case Number 201605414 & 201605419 - Report issued in November 2017

Ms A complained about the care provided to Mrs B by Betsi Cadwaladr University Health Board and her GP through the Home Enhanced Care Service ("HECS"). Ms A specifically complained that Mrs B was not admitted to hospital but referred to HECS in January 2016, and that the poor care provided and the failure to identify Mrs B's pneumonia, resulted in Mrs B's deterioration and led to her emergency admission to hospital on 7 February and her death a week later.

The investigation found that the care and management provided to Mrs B by the HECS Team and the GP, including the decision on 29 January 2016 to refer her to HECS, was reasonable and appropriate based on Mrs B's presenting condition and symptoms at the relevant times. In addition, Mrs B's sudden deterioration on 7 February could not have been predicted based on her clinical status. Accordingly, Ms A's complaints were not upheld.

The Ombudsman's Casebook

Abertawe Bro Morgannwg University Health Board – Appointments/admissions/discharges and transfer procedures

Case Number 201607083 - Report issued in November 2017

Mrs X had aortic stenosis (restricts blood flow from the left ventricle to the aorta). She was admitted on 24 June 2015 to Withybush Hospital and an ultrasound of her heart confirmed severe aortic stenosis. On 25 July, Mrs X was transferred to Morriston Hospital, where on 10 August 2015 she had an aortic valve replacement. On 16 August, Mrs X was discharged home at 2.00pm and she died at 9.00pm. Mr X complained about his late wife's management and discharge from hospital on 16 August 2015.

The Ombudsman found that Mrs X's management and discharge on 16 August had been appropriate and the complaint was not upheld.

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

Case Number 201700479 - Report issued in November 2017

Mr X complained that GPs at his local practice failed to identify symptoms of cancer in his late wife, Mrs X, despite seeing her on a number of occasions during 2013 and 2014. Mr X complained that the GPs had failed to undertake - or refer Mrs X for - further tests and investigations. He complained that this resulted in an avoidable delay in identifying the cancer from which she sadly died in December 2014.

The Ombudsman found that although Mrs X had attended the practice multiple times, the care she received was appropriate in response to the symptoms she displayed. The Ombudsman found no evidence that the GPs had failed to identify symptoms of cancer and was satisfied that appropriate tests and investigations were undertaken. The Ombudsman did not uphold the complaint.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201605002 - Report issued in November 2017

Mr X complained that staff at the Royal Gwent Hospital's ("the Hospital") Emergency Department (ED) failed to properly assess his wife's ("Mrs X") condition when she arrived by ambulance on the evening of Sunday, 25 September 2016. Mr X said she had been suffering from a seizure and spent nearly three hours in the back of an ambulance and another six hours in the corridor on a trolley and during that time her health was deteriorating. He said that it was only realised she had suffered a stroke after a scan the following morning. Mr X considered that had she been assessed properly, she might not have had a second stroke, which happened while she was in the Hospital.

The investigation found that there had been a considerable delay before Mrs X was seen by a doctor in the ED, which amounted to service failure. However, the overall care and treatment provided to Mrs X was found to have been of a reasonable standard. There was no evidence that the delay in being seen caused any significant detriment to Mrs X. Therefore, the complaint was partially upheld.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital

Case Number 201607451 – Report issued in December 2017

Miss A complained that the care and treatment provided to her son, B, at the Dental Unit of the Royal Alexandra Hospital ("the Unit") was not adequate. She also raised concerns that the dentists at the Unit did not identify a genetic condition as the cause of B's tooth decay when he received treatment there between May 2013 and October 2015.

The Ombudsman found that the care and treatment afforded to B during this period was of a reasonable standard and that it was not within the expertise of the dentists at the Unit to diagnosis B's genetic disorder. The complaint was not upheld.

The Ombudsman's Casebook

A Dental Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital

Case Number 201702016 – Report issued in December 2017

Mrs X complained that there was a delay in treating the cause of her front tooth pain which led the Dental Practice to carry out inappropriate root canal treatment. Mrs X also complained that there was a failure to appropriately treat her remaining front teeth after the treatment and she was left with a protruding tooth. Mrs X also said that the root canal treatment caused the post of her crown to snap and led her bridge to fall out which meant she had to accept dentures, which were also damaged due to the Dental Practice's treatment.

The investigation found that the care and treatment was appropriate and that Mrs X's treatment plan and options were discussed in detail and agreed. The investigation also found that the risks associated with root canal treatment and retaining a dental bridge were discussed and unfortunately materialised in Mrs X's case. The Ombudsman was satisfied that this was not due to any inappropriate care. The Ombudsman did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Number 201606846 – Report issued in December 2017

Mr X complained about the care and treatment his partner, Ms Y, received by Abertawe Bro Morgannwg University Health Board ("the Health Board"), at Morriston Hospital on 16 October 2014. In particular, he complained that:

- Ms Y experienced significant delays in receiving appropriate examinations and treatment;
- Ms Y's head and neck were not immobilised at the earliest opportunity; and
- Mr X was discriminated against by hospital staff, due to his physical appearance, which he said had a negative impact on the level of care that Ms Y received.

In relation to the first complaint the Ombudsman found that, whilst there was a delay in Ms Y being seen by a doctor, this delay was unreasonable as the Emergency Department was extremely busy that day and the Ombudsman's Adviser has confirmed that Ms Y appeared safe to wait.

In relation to the second complaint the Ombudsman found that, there was no indication that Ms Y's neck should have been immobilised when she arrived at the Emergency Department. The Ombudsman was satisfied that Ms Y's neck was immobilised at the earliest opportunity.

In relation to the third complaint the Ombudsman found no evidence to suggest that Mr X was discriminated against due to his physical appearance.

Mr X's complaints were not upheld.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital

Case Number 201607546 – Report issued in December 2017

Mr Y complained about the care provided by Betsi Cadwaladr University Health Board ("the Health Board") to Miss X on 14 August 2016 (Sunday) when she thought she was in labour and was turned away from the maternity ward. Mr Y complained that due to the midwife's failure to listen to Miss X, she was sent home where he delivered his child a short time later with the assistance of the emergency services.

The investigation found that the midwife's actions were in line with clinical guidelines and local policies and the care Miss X received was appropriate. Accordingly, Mr Y's complaint was not upheld.

Cwm Taf University Health Board – Clinical treatment in hospital

Case Number 201607093 – Report issued in December 2017

Mrs L complained about the care provided to her late husband by Cwm Taf University Health Board between June and October 2015. The investigation considered whether it could have been identified sooner

that Mr L's cancer had spread following the end of his chemotherapy, and, secondly, whether a stent and nephrostomy tube were correctly inserted, and whether the nephrostomy tube was removed too soon.

The Ombudsman found that the recurrence of Mr L's cancer was identified in a timely manner. Whilst the stent was initially misplaced when it was inserted, this was identified and acted on. The Ombudsman found that it was appropriate to remove the nephrostomy tube at the time it was done. The Ombudsman did not uphold the complaints.

Hywel Dda University Health Board – Appointments/admissions/discharge and transfer procedures Case Number 201606971 – Report issued in December 2017

Ms B complained about the post-discharge care that she received following a total knee replacement operation that she underwent at Bronglais Hospital in October 2015. Ms B complained that:

- Aneurin Bevan University Health Board ("the Health Board") failed to adequately assess her post-discharge care needs and failed to provide her with the post-discharge care support that she requested.
- The Health Board subsequently declined to reimburse her for costs incurred in purchasing equipment and private homecare that she felt entitled to receive from the NHS free of charge.

The Ombudsman, assisted by his Clinical Adviser did not uphold Ms B's complaints. He found that the assessments of Ms B's needs that were carried out by the Health Board were thorough and detailed and that Ms B's circumstances did not warrant a referral to Social Services as she did not have an identified need.

He also found that Ms B was not eligible for homecare support and that her discharge had been conducted in accordance with relevant guidelines. As such, there were no grounds for the Health Board to retrospectively reimburse any costs that Ms B incurred.

Welsh Ambulance Services NHS Trust – Ambulance Services Case Number 201605507 – Report issued in December 2017

Miss X complained that when her mother, Mrs Y, had been unwell at home and a visiting GP had said that she needed to be admitted to hospital, her condition was categorised incorrectly (as "Green"). Miss X considered that Mrs Y should have been viewed as an emergency case. Miss X was also aggrieved that the call-handler did not properly take into account that "aortic stenosis" (a condition where the aortic valve does not open fully so that less blood passes from the heart to the aorta), from which Mrs Y suffered, was life-threatening.

The investigation found that the initial categorisation of Mrs Y's condition had been appropriate, based on the information available to WAST at the time. Further, given that the prioritisation of a case was determined by a system of scripted questions, the call-handler could not reasonably be criticised for failing to appreciate the seriousness of Mrs Y's condition. Whilst there was a delay in arranging a vehicle to transport Mrs Y to hospital, on balance, it was not considered that WAST's response to the request for transport was unreasonable such as to amount to service failure. Therefore, the complaint was not upheld.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Aneurin Bevan University Health Board – Appointments/admissions/discharges and transfer procedures Case Number 201702171 – Report issued in October 2017

Mrs A complained about the delay in providing follow-up paediatric appointments to her young son, B. On three separate occasions, Aneurin Bevan University Health Board ("the Health Board") had failed to offer B appointments as clinically scheduled and only did so when she chased matters up with them.

The Health Board explained that there had been some issues with the scheduling of paediatric follow-up

appointments including administrative and clinic capacity issues. It had taken and was continuing to take a number of measures to address this. The Health Board agreed to provide the relevant monthly figures in six months' time (by 2 April 2018) to the Ombudsman to evidence that the measures that it had taken had lessened the delay in offering appointments. The matter was also brought to the attention of HIW.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201703846 – Report issued in October 2017

Mr A complained that he was provided with contradictory information regarding his late mother's, Mrs B, condition and questioned why her death certificate recorded her cause of death as metastatic lung cancer. Mr A also complained that his mother suffered from bedsores and had a fall on the ward during her admission before she died in January 2017. Although Mr A had received a complaints response from Betsi Cadwaladr University Health Board ("the Health Board") it was incomplete. Mr A also submitted a further complaint relating to his significant concerns about the care and treatment provided to his late mother before her death.

Although the Ombudsman declined to investigate Mr A's complaint, he recognised that Mr A had been provided with an incomplete response and required a second complaints response to address all of his concerns. However, in light of the time already taken to provide an incomplete complaint response, he was concerned that any further response should be provided to Mr A as a matter of urgency.

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

- (a) to provide Mr A with a second (complete) complaints response to all of his concerns

- (b) to offer Mr A a time and trouble payment of £100 in recognition of the shortcomings in its complaints handling.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Number 201703375 – Report issued in October 2017

Mrs X complained about the care and treatment that her son received as an inpatient at the Ablett Unit in March 2017. Mrs X also expressed concerns about her son's care in 2014, 2015 and 2016. Mrs X complained that she was dissatisfied with Betsi Cadwaladr University Health Board's ("the Health Board") response to her complaint.

The Ombudsman noted that Mrs X had provided the Health Board with an outline of her son's experience during his admission, but she omitted to raise any specific concerns about his care. Rather, Mrs X had raised historical issues concerning family and personal history, psychiatric history, and her disagreement with the medical professionals' decision about her son's mental health. The Ombudsman found that the Health Board had previously addressed these issues, but recognised that it may be helpful if Mrs X had received an explanation about her son's care in March 2017.

The Health Board agreed to:

- a) Write to Mrs X to explain the assessments carried out during her son's admission in March 2017; and explain any changes made to the way he had been treated following her meeting with its representatives on 5 July 2016.

It was agreed that the Health Board would write to Ms X within 30 working days of the date of the Ombudsman's letter to explain its findings.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number 201702998 – Report issued in October 2017

Ms X complained about the care and treatment that her father received whilst he was a patient at Ysbyty Cwm Cynon. Ms X complained that her father was always dehydrated and his standard of hygiene and cleanliness was unacceptable.

The Ombudsman found that Cwm Taf University Health Board (“the Health Board”) had taken reasonable steps to resolve Ms X’s concerns about her father’s hygiene and cleanliness, although he recognised that Ms X remained dissatisfied. The Ombudsman found no evidence to suggest that Ms X had previously raised any concerns with the Health Board, regarding her father’s dehydration.

The Health Board agreed to:

- a) Review the hydration charts to verify whether or not Ms X’s father was dehydrated at any stage.

It was agreed that the Health Board would write to Ms X within 30 working days of the date of the Ombudsman’s letter to explain its findings.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201702610 – Report issued in October 2017

Mrs X complained about Abertawe Bro Morgannwg University Health Board’s (“the Health Board”) handling of her request for breast reconstruction following cancer surgery. Mrs X complained that the Health Board had failed to listen to her concerns or acknowledge how traumatic an experience it had been for her.

The Ombudsman found that the Health Board had provided an explanation to Mrs X about her concerns and it had acknowledged that there had been a number of failings including administrative errors and poor communication and management of Mrs X’s breast care pathway. Although the Health Board had apologised for its failings, the Ombudsman considered that there was scope for further organisational learning by the Health Board.

The Health Board agreed to:

- a) Develop a patient story regarding Mrs X’s healthcare experience of breast reconstruction surgery and the breast care pathway.

It was agreed that the Health Board would contact Mrs X within 14 days of the date of the Ombudsman’s letter to progress this.

A GP Surgery in the area of Betis Cadwaladr University Health Board – Deregistration Case Number 201702920 – Report issued in October 2017

Ms E complained that the Surgery delisted her from its patient list unfairly, and without warning, and when she contacted the Surgery to request clarification she was given misleading information. Ms E had made comments on Facebook, which she was, subsequently, advised had breached the Surgery’s Social Media Policy. However, she was later informed that the Social Media Policy was in draft format at the time of the events.

The Ombudsman found that the Surgery had failed to notify Ms E of the reasons for its decision to remove her from its patient list, and that it may have been reasonably practicable for a warning to have been issued. He was not persuaded that Ms E’s comments, in themselves, were overtly abusive or malicious, although he accepted that the Surgery felt that the doctor/patient relationship had irrevocably broken down. He accepted that Ms E suffered further injustice because the Surgery inappropriately referred to a draft policy as the reason for delisting, which did not reflect a reasonable justification for its decision.

The Surgery 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 not notifying Ms E of the reason that the Surgery requested that she should be removed from the patient list

- b) apologise for inappropriately referring to a Social Media Policy as part of the reason for removal
- c) offer £100 as redress for failing to ensure there was a valid reason in the removal letter, and the resulting distress caused to her; and
- d) confirm to Ms E that all staff have been made aware of the learning points, and correct procedures, in order to prevent a recurrence.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Number 201703909 – Report issued in October 2017

Ms A complained about the care and treatment provided to her by Abertawe Bro Morgannwg University Health Board's ("the Health Board") maternity services. Specifically, Ms A was concerned that she acquired an infection and experienced a haematoma. Ms A said that she experienced a significant amount of pain which led to some difficulties in caring for her baby. Ms A complained that the staff did not understand the extent of her pain and that she had not been advised that a detection of sepsis had been made until a response was received to her complaint.

Ms A also complained about the community maternity services received following her discharge from hospital.

The Ombudsman identified that Ms A's concerns about the detection of sepsis and community services had not been part of her original complaint to the Health Board. It was determined that both issues required further investigation, consideration and explanation by the Health Board.

The Health Board was therefore asked to:

- a) investigate and provide a further PTR response to Ms A to explain the nature of the infection acquired and treatment offered to her.
- b) consider Ms A's concerns about the care and treatment provided by the community midwifery service following her discharge from hospital. In doing so the Health Board will seek further clarity from Ms A as to the nature of her concerns.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201703664 – Report issued in October 2017

Mr A complained that Hywel Dda University Health Board ("the Health Board") had failed to respond to serious concerns raised about a delayed diagnosis and care. Mr A was informed that he would receive a response to his concerns in six months of its submission. At ten months as he had not received a response Mr A complained to the Ombudsman.

The Health Board issued an interim report to Mr A on the same day that he submitted his complaint to the Ombudsman. The report explained that Mr A's concerns would continue to be considered under the relevant redress regulations.

The Ombudsman therefore considered the complaint handling elements of Mr A's complaint only and was satisfied that there were unexplained delays and broken promises to Mr A in recent months.

In consequence the Health Board agreed to:

- a) apologise to Mr A for the delay in providing him with an interim report in respect of his complaint and failing to issue it as promised, and
- b) make a payment of £100 in recognition of the time and trouble taken in pursuing his complaint with the Ombudsman.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201703797 – Report issued in October 2017

Ms X complained about the care and treatment offered to her late partner, Mr Y, by Cardiff and Vale University Health Board (“the Health Board”) between 2013 and 2015. Although Ms X had complained to the Health Board in January 2016, by the time that she referred the complaint to this office, she was yet to receive a formal written response. The Ombudsman therefore considered the complaint to be premature.

However, as it appeared that the complaint response had been delayed, he asked the Health Board to carry out the following actions within 30 working days of his closure letters:

- (a) A payment of £500 to reflect the Health Board’s poor complaints handling together with a letter of apology
- (b) A payment of £250 to reflect her time and trouble in raising the complaint with this office
- (c) A formal written response to her original complaint
- (d) A discussion with the complaints co-ordinator concerned and the wider complaints team regarding the role of this office and the timescales in which we would expect a complaint to be made; and
- (e) A discussion with the complaints team to outline that complaint meetings should be arranged as promptly as possible.

The Health Board agreed to the above proposals. The Ombudsman advised the complainant that she could approach his office again if she was dissatisfied when she had received and considered the Health Board’s written response.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Number 201704117 - Report issued in November 2017

Ms A complained on behalf of the late Mrs B. Ms A said that Mrs B lived in a care home and had no living family. When making health and welfare decisions, Mrs B was represented by the Independent Mental Capacity Advocacy (“IMCA”) service.

In June 2017, Mrs B was admitted to hospital, where, contrary to the Mental Capacity Act 2005, numerous “best interest” decisions were made about her care and treatment, including the decision to implement a “Do Not Attempt Cardiopulmonary Resuscitation” directive without the presence of any representative for Mrs B.

In response to the complaint, Betsi Cadwaladr University Health Board (“the Health Board”) agreed to undertake the following action:

- a) Identify the clinicians involved in this matter and discuss Ms A/Mrs B’s complaint during their supervision sessions
- b) Refer the case to the Health Board’s Equalities and Human Rights team for review and identification of learning points
- c) Consider using the case as a learning exercise within the clinical governance arrangements
- d) Conduct an audit of DNACPR orders made within the last 12 months without the benefit of discussion with the patient, their family or advocate to ensure they were appropriately made
- e) Remind all staff of their responsibilities under the Mental Capacity Act 2005 and the need to consider whether an IMCA should be contacted for patients who do not have capacity to make a decision. This will be left to the Health Board to determine the most suitable means to achieve this
- f) Invite Ms A, in her capacity as IMCA for Conwy and Denbighshire Mental Health Advocacy Service, to be involved in any learning exercise.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201701969 - Report issued in November 2017

Mr A complained about his mother's care when she attended the Emergency Department following a fall. He said that a fracture of a bone in her pelvis was not noted and therefore the care home to which she returned was not told about it, resulting in his mother being inappropriately mobilised; he said that his mother was discharged with her prescribed medication, and without a planned assessment having been carried out. Mr A also complained about the time taken by Hywel Dda University Health Board ("the Health Board") to respond to his complaint.

After taking advice from a professional adviser, the Ombudsman was satisfied that Mr A's mother's treatment - mobilisation and pain relief - would have been the same even if the fracture had been diagnosed. The Health Board produced an action plan to prevent a recurrence of the failings which it had already identified, and agreed to apologise to Mr A for these and to make a payment of £300 to him in recognition of the delay in its complaint response. The Ombudsman considered this to be a reasonable settlement of the complaint and therefore discontinued his investigation.

Powys Teaching Health Board – Continuing Care Case Number 201703118 - Report issued in November 2017

The Ombudsman considered a complaint about a retrospective review for NHS Continuing Healthcare eligibility dating back to 1996. Powys Teaching Health Board ("the Health Board") had carried out a review of eligibility going back to 2003. However, the Ombudsman found that the initial claim had been made prior to 15 August 2010 (which was the cut-off date for claims prior to 2003) and therefore the period prior to 2003 should also have been considered. The Health Board agreed to carry out a review of the period prior to 2003 when the claimant had been resident in the care home.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case Number 201703908 - Report issued in November 2017

Mr and Mrs X said that their daughter, Ms Y, had received an immunisation from the School Nursing Service for Betsi Cadwaladr University Health Board ("the Health Board") on 4 April 2017. The Health Board said that standard practice was that children should be observed for fifteen minutes post immunisation however, on this occasion, the venue for the immunisation did not permit this and children were instead told to wait in the vicinity for fifteen minutes. It appeared that Ms Y may have suffered a fainting incident during the fifteen minutes post immunisation, as a result of which Mr and Mrs X said that she suffered injuries.

The Health Board accepted that its initial complaint investigation was not as comprehensive as it might have been. It agreed to take the following actions:

- (a) To carry out a thorough investigation of the complaint made and to reach and issue its conclusions to the complainants and the Ombudsman no later than 22 December 2017.
- (b) Should the Health Board decide to uphold the complaint following the investigation, it would give consideration to any wider points of learning that may flow from the complaint and action those wider points of learning.

Cardiff and Vale University Health Board – Appointments/Admissions/Discharges and Transfers Case Number 201704049 - Report issued in November 2017

Mrs A complained that a recording of her consultation with a consultant spinal surgeon became corrupted which meant she was not discharged and referred to a neurologist. She also complained about the attitude and behaviour of a consultant who carried out a further appointment which had been arranged to address the issue of the corrupt recording.

The Ombudsman declined to investigate Mrs A's complaint based on the action taken (apology and further appointment) and explanations provided by Cardiff and Vale University Health Board ("the Health Board") in relation to the corrupt recording and because there was no independent person present at the further consultation. However, the Ombudsman contacted the Health Board and it arranged an urgent neurologist appointment for Mrs A.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case Number 201703694 - Report issued in November 2017

Miss A complained that she was provided with a false positive HIV blood test result and this result had been recorded in her medical records.

The Ombudsman declined to investigate Miss A's complaint as it appeared that Aneurin Bevan University Health Board ("the Health Board") had already thoroughly investigated the matter as a serious incident and little more could be achieved. However, the Ombudsman contacted the Health Board and it agreed to provide Miss A with a copy of her clinic notes to reassure her there was no record of the positive HIV blood test result in her notes.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201704415 - Report issued in November 2017

Ms M complained about the care and treatment she received whilst a patient under the care of the Cardiff and Vale University Health Board ("the Health Board"). Ms M attended Accident and Emergency ("A&E") after suffering a fracture to her leg. Ms M complained that she was discharged the following day without a mobility assessment being undertaken. Ms M said that she became dependent on others for support for which additional expenses were incurred.

The Health Board identified that on this occasion staff failed to carry out the necessary mobility assessment before Ms M was discharged from A&E.

The Health Board has apologised to Ms M and has agreed to undertake the following proposals within one month:

- a) Pay Ms M the sum of £50 for out of pocket expenses
- b) Pay Ms M the sum of £50 for any inconvenience caused following her discharge

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number 201705770 – Report issued in December 2017

Mrs X complained about the care and treatment provided to her late mother, Mrs Y, by Abertawe Bro Morgannwg University Health Board ("the Health Board"). Mrs X subsequently complained that she was awaiting a response from the Health Board following a meeting held on 1 December 2017.

The Health Board agreed to issue its response by 31 January 2018 to the issues raised in the meeting.

Hywel Dda University Health Board – Clinical treatment in hospital Case Number 201705070 – Report issued in December 2017

Ms A complained about her difficulty in re-scheduling an appointment for her therapy session after it was cancelled by the Health Board in February 2016.

On receipt of the complaint, the Ombudsman contacted the Health Board. It disputed that there had been any failure to re-schedule the appointment and agreed to undertake the following in settlement of the complaint:

- Write to Ms A within two months of the date of this decision setting out the timeline of events fol-

lowing the cancellation of her appointment supported by copies of any relevant records.

- Offer a further appointment for assessment of her current health care needs.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number 201702248 – Report issued in December 2017

Mrs X complained that Cardiff and Vale University Health Board (“the Health Board”) failed to refer her daughter, Ms Y, to an Ophthalmologist at the earliest opportunity. In particular, Mrs X highlighted two instances where she believed that her daughter should have been referred, these being:

- An A&E attendance on 8 August 2014; and
- A Health Visitor review on 27 August 2014.

During the investigation, the Health Board acknowledged that Ms Y should have been referred to an Ophthalmologist on 27 August 2014. It was subsequently agreed that the Health Board would take the following action in settlement of the complaint:

To instruct an Independent Expert to review the care provided to Ms Y, by the Health Board, between 8 and 27 August 2014, and to consider whether any harm was caused to Ms Y as a result of the Health Board’s failure to refer her to an Ophthalmologist on 27 August. The Health Board agreed to provide Mrs X with a response within three months of the date of this letter.

Betsi Cadwaladr University Health Board – Appointments/admissions/discharges and transfer procedures

Case Number 201704349 – Report issued in December 2017

Mr A complained to the Ombudsman about several occasions when communication around arrangements for his appointments had not been clear and staff at his Community Mental Health Team had failed to return his telephone calls. Although Mr A had raised his concerns with Betsi Cadwaladr University Health Board (“the Health Board”) and it had given assurances that changes would be made, in his experience, the service did not improve.

On receipt of the complaint, the Ombudsman contacted the Health Board and it agreed to undertake the following within four weeks to resolve Mr A’s concerns:

- a) Incorporate any actions outstanding from Mr A’s complaint and some new recommendations suggested by the Ombudsman into a formal action plan to be shared with Mr A.
- b) Apologise to Mr A and make him redress payment of £100 in recognition of the poor communication he has continued to experience

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number 201704563 – Report issued in December 2017

Mrs H complained about care and treatment provided to her husband, up to and following his diagnosis of terminal cancer in January 2015, and through his decline until his death in August 2015. Mrs H said that she and her husband did not receive appropriate support, and were not kept informed about her husband’s condition, or important test results and were not involved in important clinical decisions.

Mrs H raised a complaint on 23 November 2015, and met with Aneurin Bevan University Health Board (“the Health Board”) on 14 March 2016; a formal response was then issued on 15 August 2016. Mrs H raised further queries with the Health Board in October 2016 and it had agreed to arrange a meeting and provide a further response. However, despite several update requests, no further response had been forthcoming.

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

- a) Apologise for, and explain, the significant delays in arranging a meeting, as agreed, and providing a response, following Mrs H's further concerns from October 2016;
- b) Offer financial redress at the sum of £500; and
- c) Provide a full and final written response.

Cardiff and Vale University Health Board - Other Case Number 201704886 – Report issued in December 2017

Ms D complained about the Cardiff and Vale University Health Board ("the Health Board") on behalf of a family member. Ms D said that her relative was distressed when he was refused information about a patient in Hospital.

The Ombudsman found that the Health Board's complaint response did not sufficiently address the issues raised and it has agreed to the following recommendations:

- a) write to Ms D's relative with an apology for not fully addressing the issues raised in the original complaint
- b) explain the Health Board's legal obligations to Ms D's relative
- c) explain the Health Board's responsibilities under the Freedom of Information Act 2000 to say whether or not Ms D's relative is entitled to personal information under the regulations of the Act.

Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case Number 201704645 – Report issued in December 2017

Mr Z complained about Betsi Cadwaladr University Health Board's ("the Health Board") failure to effectively communicate with him when the dental department where he had been receiving treatment closed. Mr Z was concerned that he was not told who would be responsible for his care and what his ongoing treatment options would be. Subsequently Mr Z expressed concern that it was necessary for him to chase a referral made to a hospital outside of the Health Board and also complained that a letter relating to his complaints sent to his Assembly member contained factual inaccuracies.

The Ombudsman agreed that communication from the Health Board was not consistent or satisfactory during the period complained about. It was noted also that the letter referred to did not fully and correctly detail the sequence of events during this period.

The Health Board was asked to:

- a) apologise to Mr Z for the communication issues identified by his complaint.
- b) identify a single point of contact for Mr Z for all future dealings with the Health Board.

Cardiff and Vale University Health Board – Clinical treatment in hospital Case Number 201705282 – Report issued in December 2017

Mr H complained about the decision of Cardiff and Vale University Health Board ("the Health Board") to close his complaint as out of time.

Mr H's complaint about a root nerve block procedure ("the procedure") was made to the Health Board more than twelve months after the procedure was undertaken. The Health Board and the Ombudsman saw no evidence that the complaint could not have been made sooner. The Ombudsman did not consider the Health Board's decision to close the complaint to be unreasonable.



The Ombudsman's Casebook

However, the Health Board agreed to consider and respond to the matters Mr H raised by 31 January 2018, outside of The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Benefits Administration

UPHELD

City and County of Swansea – Housing Benefit

Case Number 201705587 – Report issued in December 2017

Ms B complained to the Ombudsman saying that the City and County of Swansea (“the Council”) failed to mitigate her losses after she had raised concerns about payment of Housing Benefit.

The Ombudsman found that there was evidence of maladministration and in recognition for its failing the Council agreed to:

- a) pay Ms B the sum of £250 for the time and trouble taken to raise her complaint and for any inconvenience caused

Complaint Handling

UPHELD

Betsi Cadwaladr University Health Board - Health
Case Number 201607830 - Report issued in November 2017

Mr A complained about Betsi Cadwaladr University Health Board's ("the Health Board") delay in responding to his complaint about the care of his late wife. The Health Board took 18 months to respond to him.

The Ombudsman's investigation found that the Health Board's handling of Mr A's complaint had been nothing short of woeful and his complaint was upheld.

Amongst the recommendations the Ombudsman made were that the Health Board should apologise to Mr A for the failings in the way his concerns had been handled and it should pay him the sum of £300 in recognition of the significant time and trouble he had been put to in pursuing the matter.

Betsi Cadwaladr University Health Board - Health
Case Number 201606684 - Report issued in December 2017

Mrs A's complaint concerns the management and care provided to her late mother by the Health Board's Cancer Care Services in 2014. Mrs A complained that during an outpatient clinic on 18 March the Consultant Haematologist ("the Haematologist") failed to advise her mother ("Mrs M") to undergo further investigations of the lump in her breast. Mrs A added that had her mother been made aware her leukaemia was progressing she would not have had the mastectomy. Mrs A also complained about Betsi Cadwaladr University Health Board's ("the Health Board") delay in responding to her complaint.

The Ombudsman's investigation found no reason to have concerns about the clinical care that Mrs A received other than from 2014, when Mrs A's condition was declining due to her progressive leukaemia and subsequent breast cancer diagnosis. He therefore did not uphold this aspect of Mrs A's complaint.

However, the investigation identified instances of poor communications between the clinicians involved in Mrs M's care and in the way they communicated with the family about her condition and treatment plans and therefore upheld this aspect of Mrs A's complaint.

In relation to the Health Board's delay in responding to her complaint, the investigation identified that the complexity of Mrs M's case meant that some delay in the Health Board providing a response was inevitable, but the Ombudsman felt that the delay in Mrs A's case went beyond what was reasonable. As a consequence, this meant Mrs A and the family had to engage in further protracted communication at a difficult time for the family. Since this aspect of Mrs A's complaint had previously been addressed by the Ombudsman he made no further finding in relation to this part of Mrs A's complaint.

Amongst the recommendation the Ombudsman made were that the Health Board should:

- a) apologise to Mrs A for the failings identified by the investigation
- b) pay Mrs A the sum of £500 in recognition of shortcomings in communication and ongoing distress to her and her family
- c) remind clinicians that when decisions are made by a MDT it must involve all the relevant clinical teams
- d) make it clear who has overall lead responsibility for a patient's clinical pathway including their holistic and palliative care.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Betsi Cadwaladr University Health Board - Health Case Number 201704294 – Report issued in October 2017

Mr X complained about Betsi Cadwaladr University Health Board's ("the Health Board") handling of his complaint. In particular that he had not received a response to the concerns he raised.

The Ombudsman contacted the Health Board and was informed that the delays were because it was awaiting information to finalise the outcome.

The Health Board also informed the Ombudsman that the information it was awaiting had been received and a response would be sent by 31 October 2017.

Hywel Dda University Health Board - Health Case Number 201703377 – Report issued in October 2017

Ms X complained about Hywel Dda University Health Board's ("the Health Board") handling of her concerns surrounding the death of her sister following a routine hip operation in 2015. In particular, that she had not received a response at the time of approaching the Ombudsman.

The Health Board recognised failings in the handling of the complaint and advised its investigation concluded in July. A response letter was sent for signing but it was overlooked and never posted.

After recognising its failure the Health Board posted the response to Ms X with a covering letter. The Ombudsman was disappointed to note that it offered no explanation for the delay.

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

- a. Re-issue an apology letter explaining that the response was not sent and the reason why, no later than 13 October.
- b. Re-issue the decision letter with the correct date of September, no later than 13 October.
- c. Pay an ex gratia payment of £125 in recognition of this oversight, no later than 13 October.

Hywel Dda University Health Board - Health Case Number 201703109 – Report issued in October 2017

Ms X complained about the lack of care she received from Hywel Dda University Health Board's ("the Health Board") Crisis Team¹ and the inappropriate way members of staff treated her.

Ms X was referred to the Crisis Team by her GP following the death of her five-year-old son. She complained that staff spoke to her inappropriately and had walked out of her house leaving her distressed. She also complained that she has been waiting over 15 months for a complaint response.

Ms X also expressed her concerns that she had been told by a nurse who no longer works for the Health Board that during a visit when Ms X was clearly distressed, the person in charge of the Crisis Team refused to allow one member of staff to attend to her and another member refused to and left the building through the fire escape.

The Health Board recognised that it has failed in its handling of this complaint, partly because some of the concerns were being considered by the Council's Safeguarding Team. It had recently held a meeting to discuss this matter and how to best move forward.

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

¹

- a) Write to Ms X with an apology and explanation for the delay, no later than 13 October 2017
- b) Give an undertaking to expedite the response and update Ms X regularly in the interim.
- c) Provide Ms X with a financial redress in the amount of £300 in recognition of the poor complaint handling, no later than 31 October 2017.

Hywel Dda University Health Board - Health Case Number 201702389 – Report issued in October 2017

Mr X complained that Hywel Dda University Health Board (“the Health Board”) failed to respond to his complaint concerning the care of his daughter.

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

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

Abertawe Bro Morgannwg University Health Board - Health Case Number 201704347 – Report issued in October 2017

Ms A complained that Abertawe Bro Morgannwg University Health Board (“the Health Board”) had failed to respond to the complaint she made in August 2016 about the care and treatment provided to her late mother. Ms A also complained that the Health Board had not updated her during the course of its investigation.

The Ombudsman considered that there had been an unacceptable delay in the Health Board responding to Ms A, and that it had failed to provide meaningful updates to Ms A during the course of its investigation, other than when Ms A requested updates herself.

In settlement of the complaint, the Health Board agreed to complete the following actions by 20 November 2017:

- a) Issue the complaint response
- b) Apologise to Ms A for the substantial delay in responding to the complaint
and for the lack of meaningful updates during the course of the Health Board’s investigation
- c) Explain the reasons for the substantial delay in responding to the complaint
- d) Offer a payment of £500 to Ms A for the time and trouble in raising her complaint with the Ombudsman, and in recognition of the substantial delay in responding to the complaint, and the lack of updates provided by the Health Board.

Flintshire County Council – Environment/Environmental Health Case Number 201704104 – Report issued in October 2017

Mr F complained about Flintshire County Council’s (“the Council”) handling of his complaint to it about repeatedly missed refuse collections.

The Ombudsman found that the Council had failed to respond to Mr F in accordance with its own complaints procedure. The Council had left a brief voicemail message for Mr F on the final day of its Step 1

complaints procedure timescale. The voicemail message had not been followed up by the Council.

In settlement of the complaint, the Council agreed to complete the following actions by 23 November 2017:

- a) Apologise to Mr F for failing to respond to his Step 1 complaint in accordance with its own complaints procedure
- b) Provide Mr F with a formal written response to his complaint
- c) Communicate to relevant staff that, where a Step 1 response to a complaint is being made by way of an unrecorded telephone call, ensure that notes of the call are made
- d) Inform relevant staff that, where a complainant does not respond to a Step 1 telephone call, or is not happy with the content of the telephone call, to follow up with a formal letter or email to the complainant.

Cwm Taf University Health Board - Health Case Number 201703308 – Report issued in October 2017

A solicitor complained on behalf of their client that Cwm Taf University Health Board (“the Health Board”) had failed to take into account their client’s lack of mental capacity when refusing to accept a complaint about care provided following a hip replacement operation in 2015 as it was out of time.

The Ombudsman considered that the Health Board had responded to the solicitor’s correspondence in a timely manner, and had correctly informed the solicitor of the 12 month time restrictions under The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (“the Regulations”).

However, the Health Board, in accordance with Paragraph 15 of the Regulations, had failed to explain the reasoning for its decision not to accept the concern as out of time, and did not evidence that it had taken the solicitor’s client’s lack of capacity into consideration.

Therefore, in settlement of the complaint, the Health Board agreed to:

- a) Apologise within 20 working days for failing to provide its reasoning for the decision taken
- b) Reconsider, in accordance with paragraph 15 of the Regulations, whether the solicitor had good reasons for not notifying the concern within the 12 month time limit, and whether it remains possible to investigate the concern
- c) If deciding to investigate, respond to the complaint within the Regulations timescale of 30 working days; if agreeing with the original decision not to investigate, write to the solicitor within 20 working days, explaining the reasoning for the decision.

Hywel Dda University Health Board - Health Case Number 201703900 – Report issued in October 2017

Mr B complained that he did not receive appropriate care and treatment during a consultation at Wwithyush Hospital on 30 June 2016.

He believed that the Consultant had provided him with incorrect information in relation to his use of a Continuous Positive Air Pressure machine for his respiratory condition. He also stated that the Consultant had failed to examine him properly.

The consultation ended in dispute.

The Ombudsman considered the information provided to him and contacted Hywel Dda University Health Board (“the Health Board”) as a result. The Health Board agreed to:

- a) write to the complainant within 20 working days of the date of this letter and offer him an appointment with a view to having a second opinion regarding his respiratory condition.

The consultation should take place within the next three months.

The Ombudsman considered that this was a suitable resolution to his complaint.

Hywel Dda University Health Board - Health Case Number 201704193 – Report issued in October 2017

Ms J complained about delays on the part of Hywel Dda University Health Board (“the Health Board”) in dealing with her complaint. The formal concern, relating to care and treatment provided to your partner, was first raised in February but Ms J had not received a response.

The Ombudsman found that the substance of the complaint was not overly complex, and therefore should not warrant a delay to the full extension provided under the Health Board’s complaints procedure (which may be up to six months for complex cases).

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

- a) Apologise for the delay; and
- b) Offer £125 financial redress for Ms J’s time and trouble in pursuing the complaint.

Betsi Cadwaladr University Health Board - Health Case Number 201703467 – Report issued in October 2017

Ms A complained about the way Betsi Cadwaladr University Health Board (“the Health Board”) handled her complaint in relation to the care and treatment her husband received before he died on 4 July 2016. A formal complaint was raised in October 2016 but, despite receiving a holding letter in February of this year, a response still has not been received. Enquiries with the Health Board in August revealed that it had only just written up questions for the clinicians involved in the patient’s care, although it was hopeful that a response would be issued within the next three months.

The Ombudsman found that the delays were unreasonable and unacceptable, and could have been avoided, at least in part, if the complaint had been effectively monitored and reallocated when the case owner took an extended leave of absence. The Health Board agreed to undertake the following actions, in settlement of the complaint:

- a) Provide an apology, explaining the reasons for the significant delays in providing a response
- b) Offer financial redress in the sum of £500; and
- c) Provide a full and final response within ten weeks of the Ombudsman’s decision.

A GP Practice in the area of Aneurin Bevan University Health Board - Health Case Number 201702757 – Report issued in October 2017

Mrs X complained that the Surgery failed to acknowledge her complaint in respect of the care and treatment provided to a family member. Mrs X said that despite contacting the Surgery two weeks after making her complaint, the Surgery did not acknowledge her complaint.

In settlement of Mrs X’s complaint, the Surgery agreed to complete the following actions (within one month):

- a) Respond to Mrs X’s complaint in writing, explaining the action taken to date
- b) Apologise for any distress and inconvenience caused by the lack of communication

Betsi Cadwaladr University Health Board - Health Case Number 201703864 - Report issued in November 2017

Ms X complained to Betsi Cadwaladr University Health Board ("the Health Board") in January 2017. At the time of bringing the complaint to the Ombudsman in September 2017 she had still not received its outcome.

Ms X contacted the Health Board on several occasions requesting updates however, it was noted by the Ombudsman that only two holding letters were sent to Ms X, dated 23 May and 6 June.

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

- a) Apologise to Ms X for its failure in providing regular updates.
- b) Provide a meaningful update or an interim Reg 26 response within 14 days
 - to include its agreement to the suspension of the limitation period for bringing a civil claim from June 2017 up to and including six months after the date of the final PR response is issued.
- c) Offer redress in recognition of the complaint handling in the sum of £500.

Neath Port Talbot County Borough Council – Children's Social Services Case Number 201702632 - Report issued in November 2017

Mr A complained about communication matters, involving Neath Port Talbot County Borough Council ("the Council") officers in its Social Services department, including that no one would speak with him. Mr A's daughter was in foster care and he lived at some distance away in England, but exercised contact. He said that the Council had: failed to make reasonable adjustments for him in view of his disability, not investigated a concern he'd raised about his daughter's welfare, not provided him with a copy of her school report, and that it cancelled a contact visit when he had already set out from home, causing him inconvenience and to feel unwell.

Having regard to the Ombudsman's jurisdiction, and certain restrictions upon it, he felt that Mr A's complaint about officer communication should progress through Stage 2 of the statutory Social Services complaints procedure. He felt that an adjustment offer made by the Council (see below) was reasonable in enabling Mr A to access this part of its service. On examination of certain documents, the Ombudsman felt that Mr A's concerns about his daughter had been investigated at the time and, as he had parental responsibility, that Mr A was entitled to receive a copy of his daughter's end of term school report (to which the Council agreed). Further, there was a lack of clarity regarding the contact visit complained about for which the Council had already verbally apologised and offered to reimburse Mr A the abortive travel costs incurred. The Ombudsman could not otherwise get involved in any ongoing contact difficulties which were matters for the court.

In part resolution of the complaint, the following was agreed to by the Council:

- a) A reasonable adjustment to enable Mr A to engage with the Stage Independent Investigator to pursue outstanding matters by means of meeting the cost of an overnight stay locally for Mr A (and a companion if he so wished), to coincide with an agreed contact visit (the Council has since made that offer in writing to Mr A)
- b) An apology in writing (within one month) to Mr A for the breakdown in communication resulting in the abortive contact visit (an offer of travel reimbursement having already been made)
- c) An apology in writing (within one month – combined with (b) above) for not sending Mr A the copy school report to which he was entitled, and sending him that report (if not already done) with a commitment to providing copies of future reports, as soon as practicable on receipt (so long as Mr A remained legally entitled to them).

City and County of Swansea – Education

Case Number 201703688 – Report issued in December 2017

Mrs A complained that the Council had failed to ensure that the Governing Body of a local school dealt with her daughter's complaint properly in accordance with the relevant policy, or in compliance with guidance from Welsh Government. Mrs A had wanted the Council to intervene and take over the complaints process from the School.

Although the Ombudsman did not find any evidence to support that consideration of such intervention by the Council was warranted, he did identify some minor administrative failings by the School in the operation of its Complaints Procedure that had not been fully addressed. The Ombudsman contacted the Council and it agreed to undertake the following in settlement of the complaint:

- a) Apologise to Mrs A for failing to record her concerns about the LEA's involvement in witness interviews or to deal with them in accordance with the Council's own Complaint Procedure.
- b) Acknowledge that the Governing Body did not follow its own Complaints Procedure, by providing Mrs A's daughter with the same evidence as was given to the Complaints Committee, and the impact this has had on her confidence in the fairness and transparency of the process.
- c) Produce a simple guidance document for School Governing Bodies on preparing evidence bundles covering what to include and proper referencing.

Hywel Dda University Health Board - Health

Case Number 201705368 – Report issued in December 2017

Mr X complained about Hywel Dda University Health Board's ("the Health Board") handling of his complaint of January 2017 regarding knee surgeries he has received since 2013.

The Health Board had provided some updates to Mr X and his advocate during the course of its investigation. The Ombudsman saw no evidence to suggest that updates were provided to Mr X or his advocate between July and November 2017, and therefore reminded the

Health Board of the importance of providing updates when undertaking complex and/or time-consuming investigations.

In settlement of Mr X's complaint, the Health Board agreed to complete the following actions by 1 February 2018:

- a) Issue the complaint response
- b) Apologise for the delay in issuing the response
- c) Explain the reasons for the delay
- d) Offer a payment of £125 for the time and trouble in raising the complaint with the Ombudsman

Aneurin Bevan University Health Board – Health

Case Number 201703834 – Report issued in December 2017

Mr X complained that he had not received a response from Aneurin Bevan University Health Board ("the Health Board") to a complaint he raised in April 2017. Mr X and his family raised concerns about the care and treatment offered to his late father-in-law while a resident at a nursing home. Mr X also raised questions about why his father-in-law had to spend his last few months in the nursing home rather than at his own home as he wished.

After careful consideration of this complaint the Ombudsman contacted the Health Board to discuss the



The Ombudsman's
Casebook

Education

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Powys County Council – School transport

Case Number 201606912 - Report issued in November 2017

Mr X complained that Powys County Council ("the Council") failed to provide his daughter ("Miss X") with school transport to and from Gwernyfed High School between September 2014 and July 2016.

The investigation found that the Council's decision not to grant Miss X with school transport was reasonable and in keeping with the provisions of the Learner Travel (Wales) Measure 2008 and the Council's Home to School/College Transport Policy. However, the complaint was complicated by the Council's handling of Mr X's appeal, where the decision not to grant school transport was overturned. It was found that the Council's reasoning for this decision was unclear and was not supported by evidence.

As there was no evidence of maladministration by the Council in its original decision not to allow Miss X's school transport application, the complaint was not upheld and no recommendations were made.

Environment & Environmental Health

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Wrexham County Borough Council - Refuse collection, recycling and waste disposal
Case Number 201703431 – Report issued in October 2017

Mr B complained about Wrexham County Borough Council's ("the Council") refuse collection service saying that when he put his green waste outside his property for collection this was often not emptied. Mr B complained that this was an ongoing problem and after contacting the Council the problem had not yet been resolved. Mr B said that if the Council had changed the collection point he was not informed of this.

In settlement of Mr B's complaint, the Council agreed to complete the following actions (within one month):

- (a) Contact Mr B to arrange for an officer to visit the property to discuss all relevant concerns
- (b) The officer will also identify the location of the collection point to Mr B for all future collections

Rhondda Cynon Taf County Borough Council - Other
Case Number 201703564 - Report issued in November 2017

Mr B complained to Rhondda Cynon Taf County Borough Council ("the Council") about the dangers involved when negotiating a set of stone steps which were very slippery during wet weather conditions. Mr B complained to the Ombudsman saying that the Council failed to carry out a proper inspection during wet weather conditions and as result did not identify any safety risks.

The Ombudsman contacted the Council to discuss the complaint and they agreed to the following recommendations:

- a) A Highways Inspector to carry out a safety inspection of the stone steps during wet conditions to identify any risks
- b) Undertake any necessary remedial action
- c) The same Highways Inspector to revisit the site and carry out a further safety inspection following any necessary works.

Cardiff Council - Refuse collection, recycling and waste disposal
Case Number 201703446 - Report issued in November 2017

Ms W complained that she had experienced problems with numerous missed bin collections since March of this year. Ms W said she made over 30 phone calls and submitted two written complaints but Cardiff Council ("the Council") had failed to address the issue. Ms W is on the assisted list, and the situation is causing inconvenience and frustration.

The Ombudsman found that collection crews had not followed correct procedure to identify valid reasons for not collecting the waste. Furthermore, although both written complaints received response, the Council had issued the exact same letter twice and no demonstrable action had been taken to resolve the issues or improve the service provided.

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

- a) Apologise for the inconvenience caused owing to the missed collections and offer information regarding contamination and waste separation as well as assisted collection stickers, for Ms W to

make use of if she wishes;

- b) Apologise for failing to respond sufficiently to the corporate complaints of May and June and provide an update on the steps taken to address the issue with the collection crews;
- c) Confirm that Ms W's property has been placed on the "Priority List" as well as the "Assisted List" and explain what that means; and
- d) Offer £125 redress as time and trouble for the complaint handling failures and inconvenience for the service failures identified.

Ceredigion County Council – Drainage/Sewers/Culverts Case Number 201705393 – Report issued in December 2017

Mr A complained on behalf of Mr B about the legality and effectiveness of drainage works carried out by Ceredigion County Council ("the Council") in March 2017 to a footpath through land owned by Mr B. Mr A also complained that the Council had refused to escalate his complaint to Stage 2 of its complaints process.

The Ombudsman declined to investigate Mr A's complaint as the Council agreed to carry out a Stage 2 investigation and provide Mr B with a full response.

Finance and Taxation

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Wrexham County Borough Council – Finance and taxation
Case Number 201703481 – Report issued in October 2017

Mr D complained that Wrexham County Borough Council (“the Council”) had provided bilingual Council Tax forms to him that were poor in quality. The forms had many grammatical and spelling errors in the Welsh language. He had complained to the Council in 2015 but believed that it had not fully understood his complaint and continued to publish documents with errors on them.

The Ombudsman contacted the Council which agreed to,

- a) Issue a formal apology to Mr D outlining how this issue arose.
- b) Provide an assurance that the wording will be amended in time for the 2018/2019 billing period and why it is not possible to make this amendment until that time.
- c) Offer a compensation payment of £50 will be issued to Mr D by cheque.

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

Housing

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Family Housing Association (Wales) Ltd – Applications, allocations, transfers and exchanges
Case Number 201607244 – Report issued in October 2017

Mr A complained that as a result of administrative failings on the part of Family Housing Association (Wales) Ltd ("FHA"), which it had acknowledged, he and his family had not been rehoused when they should have been. Although FHA had said that Mr A would be offered the next available suitable property Mr A had concerns about how the failings had occurred.

During the course of the Ombudsman's investigation Mr A and his family were rehoused. The FHA detailed the changes it had introduced to address the administrative shortcomings that Mr A's case had revealed.

The FHA agreed to the Ombudsman's settlement proposal that it:

- a) make a financial payment to Mr A of £750 in recognition of the distress that the delay in being rehoused had caused Mr A and his family, and
- b) apologise again to Mr A for the failings.

Cartrefi Cymunedol Gwynedd - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating. double glazing)

Case Number 201702712 – Report issued in October 2017

Miss B complained that her landlord, Cartrefi Cymunedol Gwynedd (CCG), had failed to address her complaints about disrepair (including dampness and a leaking toilet pipe) for many months. She denied CCG's assertion that the problems were caused by condensation due to her lifestyle. In addition, she said that workmen sent by CCG to install a new kitchen (as part of an improvement programme) had abruptly left her home leaving the work unfinished.

The Ombudsman considered documents provided by both Miss B and CCG finding that there was inconsistency in how it recorded repairs and their completion and the kitchen work was left unfinished. There had also been a delay in the escalation of Miss B's formal complaint as per CCG's complaints policy. Whilst the Ombudsman could not (for jurisdictional reasons) definitively say whether the issues were related to dampness or condensation, the length of time Miss B had been raising issues was a concern (particularly given the recording inconsistency). CCG agreed to immediately address the unfinished kitchen work during consideration of the complaint. Otherwise, the Ombudsman proposed a resolution of Miss B's complaint and CCG agreed to implement the following actions:

- (a) A written apology to Miss B within one month;
- (b) Offer redress for her inconvenience, time and trouble in a total sum of £750, payable within one month;
- (c) Undertake an independent survey of Miss B's home, within one month, to ascertain the root cause of the dampness issues in particular (the outcome of which both parties would accept as definitive);
- (d) Share a copy of that survey with the Miss B and the Ombudsman within 21 days thereafter, with an action plan for addressing any recommendations as made within it, and
- (e) Undertake a review of the way in which it recorded works on its computerised system to ensure consistency and provide suitable training to relevant staff as a result (within one month).

Newport City Homes – Repairs & Maintenance

Case Number 201702771 - Report issued in November 2017

Ms X complained about the condition of her property at the time of letting by Newport City Homes ("NCH"). She said she was not able to move in until she had undertaken extensive cleaning and repairs and that several items of disrepair remained outstanding from this time. She also complained that NCH had refused to provide her with copies of its void inspection records.

The Ombudsman found no evidence of significant service failure by NCH in relation to the letting or in its repairing obligations. However, it had been asked to undertake repairs and improvement work that it had no obligation to. Although the Ombudsman could not say whether Ms X was entitled to the information she had requested, he did find that NCH had not responded to her information request appropriately. NCH agreed to the following actions in settlement of the complaint:

- a) carry out redecoration works in the bathroom and kitchen where there are areas of water damage
- b) consider reimbursement of Mrs X's costs in replacing water damaged doors and placing guarding along the patio wall
- c) inspect the condition of retaining walls and raised beds in the garden to establish whether any further assistance might be given with making it safe and easy to maintain
- d) write to Mrs X explaining the works it will and will not carry out with reference to its legal obligations
- e) review its procedures for responding to requests for information under the Freedom of Information Act 2000 and report its findings to the Ombudsman.

North Wales Housing – Estate management and environment

Case Number 201704737 – Report issued in December 2017

Mrs A complained to the Ombudsman about the decision by North Wales Housing ("the Housing Association") to levy a service charge for the cleaning and maintenance of a communal car park area at the scheme where she lived. She complained that the work that was being done was not to a reasonable standard and that it was not clear what the service charge covered.

In settlement of the complaint, the Housing Association agreed:

- a) to offer Mrs A a site meeting with the Grounds Maintenance Manager to discuss her concerns about the standard of work and to clarify what is expected to be done at each visit.
- b) To ensure that the Housing Association has provided adequate information to Mrs A (and the other tenants at the scheme) about the service charge, what it covers and how the costs have been worked out.
- c) To consider the repair issues raised by Mrs A and feedback to her about the action it intends to take about these.
- d) to consider on a more general level the information that the Housing Association provides to tenants about service charges, and whether it should have information on its website about service charges and what they may cover.

Mid Wales Housing Association Ltd – Right to Buy Case Number 201701521 – Report issued in December 2017

Ms A, is a secure tenant of Mid Wales Housing Association Ltd (“MWHHA”), which entitles her to a statutory Right To Buy (RTB) her home at a discount (on submitting an appropriately completed application). She complained that MWHHA did not inform her of a change in the RTB discount level in 2015, which had reduced the available discount by £8000. Ms A complained that had she been told of the impending change she would have been able to pursue the purchase of her home at the original discount price, so she had lost out financially. She also complained about how MWHHA had dealt with her complaint.

On considering the evidence available, the Ombudsman concluded that MWHHA had not informed Ms A about the impending change at the time and had not fully complied with the statutory requirement to provide certain RTB information to tenants generally. However, there was no evidence, on balance, to show Ms A would certainly have pursued the purchase at the time as MWHHA was only informed itself of the impending change seven days before its implementation, and Ms A would not likely have been able to pursue her application within that time. There was no evidence of any intention, or action, on her part to pursue a purchase since then, so the outcome would not have differed.

However, in light of the failure to provide statutory information, and that MWHHA had not identified this within the handling of her complaint, the Ombudsman proposed to resolve Ms A’s complaint on the basis of the following actions, which MWHHA agreed to implement within one month:

- (a) To apologise in writing to Ms A, and offer her redress of £500, for failing to provide the requisite information and for Ms A’s time and trouble in pursuing her complaint
- (b) To issue the required RTB statutory information to Ms A and keep it under review as required
- (c) To undertake a stock review and inform all other secure tenants of necessary RTB information including any known impending changes.

Planning and Building Control

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

City and County of Swansea – Unauthorised development Case Number 201702964 – Report issued in October 2017

Mr A complained on behalf of Mr B that an enforcement complaint made in November 2015 was not investigated until May 2017. Mr A also complained that there was a failure to respond to correspondence during the period December 2015 to April 2017 and that a complaint made in April 2017 was not dealt with in accordance with the City and County of Swansea's ("the Council") formal complaints policy.

Although the Ombudsman declined to investigate Mr A's complaint, he recognised that the Council had already accepted that due to an error, the enforcement complaint in November 2015 had been overlooked. The Council had already taken some action to resolve the matter by explaining what had happened, apologising and by promptly investigating the complaint.

The Ombudsman also identified that the Council had failed to provide a substantive response to Mr A's correspondence during the period in question and its Planning Department had replied to the complaint which contributed to Mr A's decision to bring the complaint to the Ombudsman.

Because of this, the Ombudsman contacted the Council and it agreed to do the following within three months and one month (respectively) of the date of this decision:

- a) to consider its complaints handling process and to take steps to ensure that complaints which allege poor service are effectively screened so that any service issues are identified and responded to in accordance with its formal complaints policy and not solely dealt with as enforcement complaints and/or responded to by the department in question
- b) to offer Mr B a redress payment in the amount of £350 in recognition of the uncertainty caused to him over the 17-month period, the failure to respond to correspondence and provide him with a proper Stage 2 response and for his time and trouble in pursuing the complaint.

Cardiff Council – Handling of planning application

Case Numbers 201703841, 201703917, 201703918, 201703919, 201703923, 201703924, 201703925, 201703926, 201703927 – Report issued in October 2017

A number of residents complained that Cardiff Council ("the Council") made an error when considering a planning application in 2009, in relation to a condition concerning the reservation of parking spaces and that, consequently, staff and visitors regularly park along the neighbouring residential streets causing obstruction and inconvenience. A local Assembly Member made representations to the Council and although a reply was received in 2016, two requests for further responses were not answered.

The Ombudsman could not investigate the complaint relating to the planning decision made eight years ago (for jurisdictional reasons), but found that the Council should have responded to a letter dated 12 April 2017 and an email dated 15 June 2017. The Council undertook the following actions, in settlement of the complaint:

- a) Apologise for failing to respond to the correspondence; and
- b) Provide a response to the request that the previous response (from 2016) be reviewed.

Neath Port Talbot County Borough Council – Unauthorised development

Case Number 201702403 – Report issued in October 2017

Dr V complained that Neath Port Talbot County Borough Council ("the Council") refused to inspect a building erected on land near his property, or reach a decision as to whether it should take enforcement action

in respect of the structure. Dr V also complained that when his local Councillor made enquiries into the matter he was given incorrect information as to whether it required planning permission.

The Ombudsman found that the Council had visited the site to inspect the building and consider whether planning permission should have been sought, and whether enforcement action was warranted. However, it failed to formally acknowledge Dr V's complaint or keep him informed of the actions it took in respect of the concerns he had raised. It further failed to acknowledge or respond to the subsequent service complaint.

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

- a) Apologise for failing to acknowledge the new complaint;
- b) Provide an update on the actions the Council has so far taken to investigate the concerns raised regarding the new structure and the outcome of its investigations into the service complaint; and
- c) Agree a realistic timescale within which the Council will provide its formal decision on what, if any, enforcement action is required.

Prior to the date of issue, the Council provided an apology; confirmed its formal decision; and explained its reasoning, which the Ombudsman considered demonstrated reasonable compliance with his recommendations.

Newport City Council – Rights of way and public footpaths Case Number 201704603 – Report issued in December 2017

Mrs A complained that Aneurin Bevan University Health Board ("the Council") had failed to respond in a timely fashion to objections she raised regarding a 'walking route' between her home and Bassaleg school. She had raised concerns regarding part of the footpath and the fact that previous risk assessments did not appear to have considered lighting on the route.

The Ombudsman considered her complaint and information provided by the Council. He found that previous assessments had taken place during Spring and summer months. He contacted the Council and it agreed to:

- a) Carry out a risk assessment of the route, with particular focus on the crossing over the river Ebbw, during the times when children are using the route around sunrise.
- b) The risk assessment will consider street lighting and condition under foot on the footpath.
- c) Write a letter to Mrs A providing the outcome of the risk assessment by 15 December 2017.

The Ombudsman considers that this is a reasonable settlement of this complaint.

Denbighshire County Council – Handling of planning application (other) Case Number 201705483 – Report issued in December 2017

Mr X complained about the way in which the planning officer dealt with his telephone calls and emails regarding his planning application. He said that following his complaint, he received a response from the Principal Planning Officer, which confirmed that the planning officer would contact him to confirm when they would be in a position to discuss his enquiries. When Mr X submitted his complaint to the Ombudsman, he said that he had still not had any contact from the planning officer.

Denbighshire County Council ("the Council") accepted that communication with Mr X had been poor. In order to resolve the complaint, the Council said that:

- a) The Principal Planning Officer would take over conduct of Mr X's planning proposal.
- b) The Principal Planning Officer would contact Mr X to arrange a meeting with him and the Prin-

cipal Built and Conservation Surveyor. The Council confirmed that it would provide one further meeting with Mr X on a free of charge basis to assist with the design of his dwelling.

- c) It would apologise to Mr X for its failure to contact him since October.

Both the Ombudsman and Mr X agreed that the above proposals amounted to a reasonable settlement of the complaint. Accordingly, the Ombudsman considered the complaint to be settled.

Powys County Council – Other planning matters

Case Number 201704286 – Report issued in December 2017

Mrs A complained that Powys County Council (“the Council”) failed to take enforcement action against her neighbours for their failure to comply with the terms of the planning consent issued to them in 2008. Specifically Mrs A complained that her neighbours had in effect changed the use of the property were operating a business from the property and had created an unauthorised access.

The Ombudsman noted that there were delays in the initial investigation of Mrs A’s complaints which had been duly acknowledged by the Council. The Ombudsman was also satisfied that the investigation undertaken was reasonable in the circumstances and that it identified a breach of planning control. Enquiries identified that a Planning Contravention Notice was eventually issued and is yet to expire.

However the Ombudsman was concerned by the Council’s delay in reaching its decision to issue the notice and its unfulfilled promise to update Mrs A of its determination made in complaints correspondence.

The Council agreed to:

- a) apologise to Mrs A for the delay, and
- b) to provide an explanation of its actions.

Roads and Transport

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Vale of Glamorgan Council - Parking

Case Number 201704524 – Report issued in October 2017

Mr and Mrs X complained that Vale of Glamorgan Council (“the Council”) had refused to allow Mr X’s parking permit to be renewed in Mrs X’s name, despite being aware of Mr X’s health issues.

In settlement of the complaint, the Council agreed to:

a) write to Mr and Mrs X to explain that the parking permit can be transferred to Mrs X at any time, subject to Mrs X meeting the necessary criteria

b) explain the necessary criteria which Mrs X needs to meet in order for the permit to be transferred to her

The Council wrote to Mr and Mrs X on 19 October 2017 in compliance with the above agreed actions.

Powys County Council- Road maintenance/road building

Case Number 201703537 - Report issued in November 2017

Ms X complained that Powys County Council (“the Council”) had failed to sweep a track near to her property and remove the mud and debris between Autumn 2015 and March 2017. Despite her reports to the Council, Ms X said that no contact was made with her and although the Council said it had dealt with the issue, it had not. Ms X also said that the Council should provide the same service to residents living at the top section of the track as it does to those at the bottom.

The Council agreed to take the following actions in settlement of Ms X’s complaint:

(a) Apologise to her for the failure to call her back on 6 February 2016.

(b) Apologise to her for the failure to sweep the track on one occasion when this action had been marked as complete.

(c) Ensure that the new asset management system will be set up to address the previous lack of a link between the web reporting form and the system.

(d) Ensure that the process for road sweeps and their sign off is reiterated to all area managers and supervisors.

(e) Review its complaints policy and consider whether it needs to be amended to reflect that officers from the same department should not be reviewing and responding to stage two complaints.

In respect of the second aspect of the complaint, the Ombudsman considered that the decision as to how often to sweep the top section of the track was a discretionary decision for the Council to reach. The Ombudsman therefore declined to investigate this.

Isle of Anglesey County Council - Other

Case Number 201704947 - Report issued in November 2017

Mr X complained that Isle of Anglesey County Council (“the Council”) had failed to place signs on a public right of way after agreeing to do so. This meant that members of the public continued to use a path that had been worn by trespassing on his land.

He also complained that the Council had failed to respond in a timely manner to some of his communications with it and had failed to escalate his complaint to be dealt with under its complaints procedure.

The Ombudsman considered his complaints and found that there were delays and a failure to escalate his complaint. He contacted the Council and it agreed to:

- a) provide the complainant with a letter of apology in the form of a corporate response outlining his complaint and outlining the solutions offered by it for the delay in responding to his complaints; and
- b) to offer him redress of £50 in recognition for the time and trouble taken to make his complaint.

This will be sent to him within 20 working days of the date of my decision letter to him.

The Ombudsman considers this to be a reasonable resolution of his complaint.

Cardiff Council – Transport Services

Case Number 201704552 - Report issued in November 2017

Mr P complained that Cardiff Council (“the Council”) had failed to arrange a meeting with him to discuss his concerns about changes to the Cardiff Bus Service. Mr P said that the Council had agreed that it would arrange a meeting, but despite a number of requests, no time or date had been forthcoming.

The Ombudsman found that the relevant correspondence in relation to Mr P’s concerns, and his request for a meeting, had been dealt with through the Council’s Cabinet Member process, and not through the complaints process. Consequently, the Council had not considered the matter or provided a corporate response. Nevertheless, it appeared that both a meeting and a full response were promised but neither had been forthcoming.

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

- a) Arrange a meeting with the Complainant, as agreed; and
- b) Provide a formal corporate response, to clarify the Council’s position in relation to the bus service.

Self-funding care provider

UPHELD

Hengoed Court Care Home – Care Homes
Case Number 201605173 – Report issued in October 2017

Mr C complained about the manner in which Hengoed Court Care Home (“the Care Home”) had worked out the payments in relation to his mother’s care fees. Specifically he was concerned to discover that there was a deficit on Mrs C’s account despite the fact that all the monthly standing order payments requested by the Care Home had been met and no payments had been missed.

The Ombudsman upheld the complaint. The Care Home had been under-collecting the client fees because its non-variable monthly standing order payments had been based on the weekly fee rate as opposed to a daily rate. This meant that there had been a small deficit accruing on the account every year. Whilst it had altered the way it calculated the collection of monthly fees to a daily rate in 2015, there remained a deficit on Mrs C’s account. The family had not been made aware of the deficit nor kept properly updated about the state of the account by an annual statement or similar.

The Care Home agreed to the following recommendations:

- a) A written apology
- b) Identifying other residents who may have cumulative credit/debit balances and update them accordingly; and
- c) Review the information that it provides to residents about their account status, payments and charging structure, ensuring that its standard of record keeping was in line with good practice and the National Minimum Standards for Care Homes.

Social Services - Adult

UPHELD

Flintshire County Council – Services for vulnerable adults
Case Number 201604914 – Report issued in October 2017

Ms A complained on behalf of her cousin, Miss B, about Flintshire County Council's ("the Council") decision to transfer Miss B's care and support services from the Council to the independent sector. Ms A complained that the Council used flawed criteria to assess the suitability of residents and properties for transition to a new care provider and, failed to fully consider Miss B's needs and apply them to the criteria appropriately. Ms A also said that the Council failed to adequately communicate with her, in her capacity as Miss B's Deputy for Personal Welfare, about Miss B's assessments and care.

The investigation found that whilst the Council's decision to create criteria against which to assess the suitability of the residents and their homes for transfer was reasonable, there were some concerns about the development and application of the criteria. The investigation also found that, despite being responsible for making decisions about Miss B's Care and accommodation, Ms A had not been included in Miss's B's assessments. The complaint was upheld.

It was recommended that the Council:

- a) apologise to Ms B
- b) in the event the Council choose to undertake a similar exercise in the future, it create a documented procedure and guidance, and
- c) in future, when providing affected parties with information about the resources used to develop any local criteria to aid decision making it provides an explanation of how those criteria would be used as part of the selection process.

Flintshire County Council – Services for vulnerable adults
Case Number 201603424 – Report issued in October 2017

Mr X complained about Flintshire County Council's ("the Council") decision to transfer his son, Mr Y's, care and support services from the Council to the independent sector. Specifically, Mr X complained that the criteria used to assess the suitability of residents and properties for transition to a new care provider were flawed and that the Council failed to fully consider Mr Y's needs and to apply the criteria appropriately.

The investigation found that whilst the Council's decision to create criteria for the purpose of assessing the suitability of the residents and their homes for transfer was reasonable, there were some concerns about the development and application of the criteria. The complaint was upheld.

It was recommended that the Council:

- a) apologise to Mr X and Mr Y
- b) in the event the Council undertakes a similar exercise in the future, it creates a documented procedure and guidance; and
- c) when providing affected parties with information about the resources used to develop any local criteria to aid decision making in future, it provides an explanation of how those criteria would be used as part of the selection process.

Merthyr Tydfil County Borough Council - Other Case Number 201605976 - Report issued in November 2017

Mr B complained to the Ombudsman on behalf of himself and his brother, Mr A, that Merthyr Tydfil County Borough Council ("the Council") failed to enact the residential charges review process appropriately when Mr A challenged their mother's (Mrs C) financial assessment. He also complained that it did not adequately handle the complaint he made about this matter.

The Ombudsman found that the Council did not correctly identify Mr A's correspondence as a review request and that the way in which the Council handled Mr B's concerns about this matter led to a delay in the resolution of this complaint.

The Ombudsman recommended that the Council apologise to Mr B, provide him with financial redress of £400 and provide training to its staff to ensure that future review requests are correctly identified and follow its three stage review process. In addition, he recommended that the Council amend their complaint response letters to explain to complainants what stage of the complaints process they are at and what the next steps are.

Caerphilly County Borough Council and Aneurin Bevan University Health Board Case Number 201605432 / 201605433 – Report issued in December 2017

Mr A complained about Caerphilly County Borough Council ("the Council") and Aneurin Bevan University Health Board ("the Health Board"). In relation to the Council, he said it had failed to assess his mother, Mrs A's needs, following a deterioration in her vascular dementia. He also referred to a failure by the Council to complete a Deprivation of Liberty Safeguards ("DoLS"), and initiate Protection of Vulnerable Adult ("POVA") procedures. Mr A was also dissatisfied with the Council's handling of his complaint.

Mr A's complaint against the Health Board centred on the following. He felt there had been a failure to diagnose his mother's dementia in a timely manner and he also had issues with the way that the Health Board had dealt with his complaint. Finally, Mr A complained that the Health Board and the Council failed to work in partnership and contribute to a timely NHS Funded Continuing Care ("NHSFCC") assessment process.

The Ombudsman's investigation concluded that whilst it is arguable that a DoLS application/authorisation by either the Care Home and/or the Council should have been triggered sooner, in this instance it had not caused Mrs A an injustice and therefore the Ombudsman did not uphold this aspect of Mr A's complaint.

In relation to the POVA process, the Ombudsman concluded that appropriate advice was sought from health professionals before deciding not to pursue the POVA investigation further. Again, the Ombudsman was satisfied that the process followed was reasonable and did not uphold this aspect of Mr A's complaint.

The Ombudsman concluded that in light of Mrs A's anxiety, possible depression and urinary tract infection, all of which can affect a person's cognitive behaviour, it was not unreasonable for the NHSFCC process to have been delayed until Mrs A's condition stabilised and this part of Mr A's complaint was not upheld.

In relation to complaint handling by the Council the Ombudsman was of the view that there were administrative failings in the Council's complaints handling process which amounted to maladministration. However, having considered the totality of the evidence he concluded that any injustice to Mr A was not so significant as to warrant upholding this aspect of his complaint. Regarding Mr A's complaint with the Health Board the Ombudsman concluded that Mr A had been put to unnecessary and avoidable time and trouble in pursuing his complaint and that this constituted an injustice to him. To that limited extent only the Ombudsman upheld Mr A's complaint and the Health Board was asked to apologise to Mr A.

Wrexham County Borough Council and Betsi Cadwaladr University Health Board Case Numbers 201605592 and 201606660 – Report issued in December 2017

Mr & Mrs C complained about the conduct of a Protection of Vulnerable Adults ("POVA") investigation into the care received by Mrs C's mother in a care home. Against the Council, they complained about the way in which the investigation was carried out, failings in communication, the conduct of case conferences

and the handling of their complaint. Against the Health Board, they complained about the review carried out into the actions of nursing staff at the home, the support and training to staff and the Health Board's involvement in the POVA investigation.

The Ombudsman upheld the complaints against both bodies. Both bodies had been responsible for the POVA investigation. He identified areas of concern with the investigation, which led to a lengthy delay in its completion, and the failure to consider a previous POVA investigation might possibly have influenced the outcome. Mrs C had been persistent in pursuing her concerns, but she was perceived as difficult and challenging and this might have, at least in part, accounted for communication with her being poor. Additionally, the case conference had not considered the investigation report in a sufficiently rigorous way, and attributed delay in completing the POVA process to Mrs C's actions. Furthermore, the Council's review of the process in response to Mrs C's complaint did not identify any failings and was not sufficiently robust. Finally, the Health Board had not evaluated the effectiveness of the training it had provided to staff at the care home.

The Ombudsman recommended that both bodies:

- a) apologise to Mrs C
- b) develop guidance and, if necessary, training, on working with people they find challenging, and develop an action plan to ensure the competence of those managing and undertaking POVA reviews; and
- c) both bodies, jointly, review their arrangements for multi-agency working in adult safeguarding.

Ceredigion County Council - Other Case Number 201606061 – Report issued in December 2017

Mrs K complained about Ceredigion County Council's ("the Council") Protection of Vulnerable Adults ("POVA") investigation into a referral made against her. In particular she raised concerns that the Council failed to conduct the investigation in a timely manner, explain sufficiently the reasons for this delay and properly consider the impact on her. She also complained about the Council's handling of her complaint.

In relation to Mrs K's first complaint, the Ombudsman found that the Council took just over a year to carry out its POVA investigation, which was excessive. Whilst it acknowledged the issues outside of its control that contributed to the delay, it failed to recognise those that were within its control. The Ombudsman also found no evidence that the Council considered the impact this delay had on Mrs K. The Ombudsman considered that this amounted to maladministration.

In relation to Mrs K's second complaint, the Ombudsman found that the Council allowed its complaints investigation to take almost as long as its POVA investigation. The Council had suggested Mrs K contributed to this delay by not providing an email it required, when in fact the delay was minimal.

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

- a) a written apology, and
- b) separate financial redress for each investigation delay.

NOT UPHELD

Caerphilly County Borough Council and Aneurin Bevan University Health Board Case Number 201605432 – Report issued in December 2017

Mr A complained about Caerphilly County Borough Council ("the Council") and Aneurin Bevan University Health Board ("the Health Board"). In relation to the Council, he said it had failed to assess his mother, Mrs A's needs, following a deterioration in her vascular dementia. He also referred to a failure by the Coun-

to complete a Deprivation of Liberty Safeguards ("DoLS"), and initiate Protection of Vulnerable Adult ("POVA") procedures. Mr A was also dissatisfied with the Council's handling of his complaint.

Mr A's complaint against the Health Board centred on the following. He felt there had been a failure to diagnose his mother's dementia in a timely manner and he also had issues with the way that the Health Board had dealt with his complaint. Finally, Mr A complained that the Health Board and the Council failed to work in partnership and contribute to a timely NHS Funded Continuing Care ("NHSFCC") assessment process.

The Ombudsman's investigation concluded that whilst it is arguable that a DoLS application/authorisation by either the Care Home and/or the Council should have been triggered sooner, in this instance it had not caused Mrs A an injustice and therefore the Ombudsman did not uphold this aspect of Mr A's complaint.

In relation to the POVA process, the Ombudsman concluded that appropriate advice was sought from health professionals before deciding not to pursue the POVA investigation further. Again, the Ombudsman was satisfied that the process followed was reasonable and did not uphold this aspect of Mr A's complaint.

The Ombudsman concluded that in light of Mrs A's anxiety, possible depression and urinary tract infection, all of which can affect a person's cognitive behaviour, it was not unreasonable for the NHSFCC process to have been delayed until Mrs A's condition stabilised and this part of Mr A's complaint was not upheld.

In relation to complaint handling by the Council the Ombudsman was of the view that there were administrative failings in the Council's complaints handling process which amounted to maladministration. However, having considered the totality of the evidence he concluded that any injustice to Mr A was not so significant as to warrant upholding this aspect of his complaint. Regarding Mr A's complaint with the Health Board the Ombudsman concluded that Mr A had been put to unnecessary and avoidable time and trouble in pursuing his complaint and that this constituted an injustice to him. To that limited extent only the Ombudsman upheld Mr A's complaint and the Health Board was asked to apologise to Mr A.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

City and County of Swansea – Services for vulnerable adults Case Number 201703847– Report issued in October 2017

Ms X and Mr Y had entered into a Shared Lives agreement (an arrangement whereby a vulnerable adult is placed with a carer in their local community and lives with them as family or regularly visits them). Ms X said that the City and County of Swansea ("the Council") failed to award Direct Payments to Mr Y following the breakdown of a workplace day service placement which he was assessed as requiring. Following Ms X's complaint about this, a stage two independent complaint investigation said that Mr Y was entitled to Direct Payments however the Council did not agree so Ms X complained to the Ombudsman.

It appeared to the Ombudsman on the basis of paperwork provided that Mr Y had been assessed as needing the placement and that he would be entitled to Direct Payments in its absence. The Council therefore agreed to take the following actions in settlement of the complaint:

- a) Pay Mr Y Direct Payments from the breakdown of the placement to 13 December 2016
- b) Pay Mr Y the sum of £125 in respect of his time and trouble in raising the complaint with the Ombudsman
- c) Reiterate its offer of a face to face meeting with the Head of Social Services to give an apology for the failings
- d) Remind relevant staff that there was no policy that those in Shared Lives agreements could not be entitled to Direct Payments for assessed needs.

Rhondda Cynon Taf County Borough Council – Services for older people

Case Number 201703950 - Report issued in November 2017

Miss A complained that Rhondda Cynon Taf County Borough Council ("the Council") had written to her in February 2017 informing her that she had incurred a substantial debt for her mother's care home fees ("the fees"), which she was previously unaware of. Following a meeting with the Council in May, Miss A complained that she was still awaiting its decision regarding the fees.

The Council provided information to the Ombudsman on 13 November, including a copy of its decision letter to Miss A. The Council subsequently agreed to complete the following actions in settlement of the complaint:

- a) Provide a written response to Miss A regarding the fees
- b) Apologise for the significant delay in communicating its decision
- c) Offer a payment of £100 to Miss A for the distress caused by its delay, and in recognition of the time and trouble in raising your complaint with the Ombudsman.

The Ombudsman considered that the Council's letter of 13 November satisfactorily met the agreed actions a) and b). The Council agreed to complete action c) within twenty working days.

City and County of Swansea – Services for vulnerable adults

Case Number 201705204 – Report issued in December 2017

Mr T complained about care provided to Mrs A whilst she was staying in a nursing home for respite care in January 2017. Mr T explained that he raised his concerns with Mrs A's Social Worker, and then received a phone call advising that City and County of Swansea ("the Council") had investigated the concerns but were not taking the matter further. When he attempted to escalate his concerns, Mr T was advised that the complaint would be referred to the same person as before, which appeared to "block" him from pursuing the matter.

The Ombudsman found that the Social Worker was clearly informed that Mr T wished to complain, and therefore his concerns should have been followed up. The Ombudsman also found that the Council did not provide sufficient information or guidance to explain the relevant complaints process to Mr T. These two things resulted in an effective failure to progress the complaint.

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

- a) Apologise for the apparent confusion and resulting delay; and
- b) Refer the matter for consideration under Stage Two of the Western Bay Safeguarding Adults Board Complaints Procedure.

Social Services - Children

UPHELD

Blaenau Gwent County Borough Council – Children in care/taken into care/at risk/child abuse/custody of children

Case Number 201605163 - Report issued in November 2017

Mr and Mrs C complained that Blaenau Gwent County Borough Council ("the Council") inappropriately removed foster children from their care and subsequently deregistered them as foster carers. Mr and Mrs C also complained about the way the Council dealt with their concerns about these matters.

The Ombudsman partly upheld the complaints. He concluded that the Council was justified in removing the children from Mr and Mrs C's care given concerns that had been raised by various professionals. However, whilst acknowledging the pressures faced by local authorities in placing children at short notice, the Ombudsman was concerned that the children had been placed in Mr and Mrs C's care in the first place, given their inexperience and the number of children involved. The placement was outside the terms of Mr and Mrs C's approval as foster carers. The Ombudsman did not criticise the Council for taking action to terminate Mr and Mrs C's approval as foster carers. He also did not uphold the complaint about how the Council dealt with Mr and Mrs C's concerns.

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Children in case /taken into care / at risk register / child abuse /custody of children

Case Number 201703942 – Report issued in October 2017

Ms F complained about Children's Social Services at Cardiff Council ("the Council"). Her concerns related to the decision making of Social Workers, who also failed to keep her informed and updated on progress, including last minute changes in contact or meeting dates. There were also concerns the Council had failed to provide adequate support to the family. Ms F also explained that she had not received any formal acknowledgement or response to her complaint, which had been resent in August, after Ms F was advised that it had not received it when it was first sent in June.

Shortly after Ms F's complaint was received, the Council issued a Stage One Complaint response. However, the Ombudsman found that it did not provide any apology or explanation for the delay and, although the complaint appeared to be upheld, there was no recognition of the effect on the complainant, or their children, and little indication of any actions taken to resolve matters and prevent recurrence.

The Council agreed to undertake the following actions, within six weeks of the date of the Ombudsman's decision:

- a) Initiate a Stage Two Complaint Investigation and appoint an Independent Investigator, in line with The Social Services Complaints Procedure (Wales) Regulations 2014;
- b) Provide a meaningful apology for the complaint handling failures so far identified; and
- c) Offer £75 redress payment, for Ms F's time and trouble in pursuing the complaint.

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

Case Number 201702980 – Report issued in October 2017

Mr Z complained about the actions of Rhondda Cynon Taf County Borough Council's ("the Council")

children's services department. Mr Z raised a number of issues relating to the accuracy of information provided to the child protection panel and which influenced its decision making, the approach taken by the service towards him and an initial failure to consult with him or provide information. These matters were considered by the Council under the complaints policy and largely upheld and appropriate recommendations made.

The Ombudsman noted that one of the issues required further explanation from the service. It became apparent that there had been some confusion relating to the timing of a test undertaken which Mr Z considered influenced a decision in November 2015 to remove his child from the child protection register. It was also apparent that some aspects of the complaint to the Ombudsman had not been raised with the Council previously.

Accordingly, the Council agreed to undertake the following within one month:

- a. Investigate and provide a further complaint response to Mr Z specifically in relation to the test referred to in the complaint.
- b. Provide written evidence demonstrating compliance with the recommendations made in the stage 2 investigation report.
- c. Provide response to the additional issues raised in the complaint to the Ombudsman.

Cardiff Council - Other

Case Number 201703388 - Report issued in November 2017

Ms X complained that Cardiff Council ("the Council") had failed to respond to the complaint she had raised in February 2017 about its Integrated Family Service Team.

The Council issued its complaint response to Ms X on the same day that Ms X's complaint was received by the Ombudsman's office.

As the Council had not apologised to Ms X for the significant delay in responding to her complaint, it agreed to complete the following actions by 29 November 2017 in settlement of the complaint:

- a) Apologise for the delay in responding to the complaint
- b) Contact Ms X in order to discuss any remaining concerns she may have to be escalated to Stage 2 of its complaints procedure.

Caerphilly County Borough Council - Other

Case Number 201703782 - Report issued in November 2017

Mr A complained about communication problems with his children's Social Worker. Mr A explained that when he raised safeguarding concerns about his children, he was ignored and his concerns were dismissed. He also said Caerphilly County Borough Council ("the Council") failed to keep him fully informed, and raised concerns about the way information was handled by the department. Mr A requested that his concerns be escalated to Stage Two of the Complaints Procedure, and waited four months to be told that the Council declined to progress it.

The Ombudsman found that the Council took too long to make and communicate its decision to Mr A. He also considered that, whilst matters were complicated by ongoing safeguarding investigations and Family Court action, some of the matters Mr A raised were legitimate concerns that should be investigated at Stage Two.

The Council agreed to undertake the following actions, within four weeks of the date of the Ombudsman's decision:

- a) Apologise for failing to deal with Mr A's request to progress his complaint to Stage Two appropriately
- b) Offer £125 as redress for Mr A's time and trouble in pursuing the complaint; and
- c) Initiate a Stage Two complaint investigation, and aim to have completed that process within two months of the date of the Ombudsman's decision.

Various Other

EARLY RESOLUTION AND VOLUNTARY SETTLEMENTS

Cardiff Council – Poor/no communications or failure to provide information Case Number 201705236 – Report issued in December 2017

Mr A and Ms B complained to the Ombudsman that they received a letter inappropriately signed by an employee at Cardiff Council (“the Council”) and that due to their personal circumstances it caused them a great deal of distress. They also felt that the Council’s complaint handling of the matter was unsatisfactory.

Although the Ombudsman declined to investigate Mr A and Ms B’s complaint, he recognised that the Council had apologised for the delay in its response handling and for the distress caused by the letter received. It had also confirmed that the employee responsible for the letter was no longer in its employment and therefore it was unable to take disciplinary action.

City and County of Swansea – Other miscellaneous Case Number 201705256 – Report issued in December 2017

Mr X complained that after exhausting the City and County of Swansea’s (“the Council”) complaints procedure and receiving its assurances that his property would be monitored and his waste would be collected, on 17 November his waste was not picked up.

The Ombudsman contacted the Council and was assured that, unfortunately, the incident was unavoidable and that all properties in the area were affected and not just Mr X’s. He was advised that the area supervisor attempted to contact Mr X on 18 November but received no answer.

The Council assured the Ombudsman that measures had been put in place, following the latest incident, to ensure collections are completed on a weekly basis. It agreed to write to Mr X to apologise and provide an explanation of the measures put in place. The Council also offered to provide Mr X with a direct line of contact to someone should your collection be missed again.

Pembrokeshire Housing Association - Other Case Number 201705135 – Report issued in December 2017

In December 2015 Mr B requested that his tenancy agreement be transferred to his daughter. Despite Mr B disputing that it should be necessary, the Housing Association repeatedly requested evidence that Mr B’s daughter had capacity to manage her own tenancy agreement before it would consider his request. However, in May of this year, it transpired that, irrespective of whether or not Mr B’s daughter has capacity to manager her own affairs, a clause present in the existing tenancy agreement precludes its transfer to another party, except in limited circumstances that do not apply to Mr B’s situation.

The Ombudsman found that the Housing Association failed to consider Mr B’s request properly and identify that the agreement already in place precluded transfer to another party. It was the Housing Association’s responsibility to ensure that it knew and understood its own tenancy contract so that it could advise you appropriately. Furthermore, there were a number of occasions when the Housing Association could have identified its error but it did not.

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) Provide a meaningful apology to Mr B for consistently requesting unnecessary information;
- (b) Offer £150 redress to him for the frustration and inconvenience;
- (c) Provide a meaningful apology to his daughter; and
- (d) Offer £150 redress to his daughter for the frustration and upset.

More information

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

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