

The Ombudsman's Casebook

Issue 35 January 2019

News

Thematic Report Published

The Ombudsman published his third thematic report since being appointed.

Home Safe and Sound: Effective Hospital Discharge highlighted 16 cases where Welsh hospitals fell short when discharging patients.

He has suggested several areas for future consideration, including training for medical staff, senior doctor involvement in the discharge process where appropriate, better communication between and within primary and secondary care organisations, and appropriate assessment to put the patient at the centre of the discharge process.

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

Council of Europe

The Ombudsman was delighted to attend a Council of Europe meeting that welcomed guests from Georgia and Abkhazia. He took part in a panel discussion on dealing with minority language complaints.



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Section 16

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

Flintshire County Council - Roads and Transport – Parking

Case Number: 201703176 – Report issued in October

Mr G complained to the Ombudsman about the manner in which Flintshire County Council (“the Council”) had authorised the removal and destruction of his vehicle, which he had parked in a parking bay outside his flat. Mr G said that the vehicle, which he was restoring, was removed without notice and destroyed and that the tools and equipment contained within the vehicle were also destroyed.

The Ombudsman’s investigation found that, whilst a Council officer said that a search of the DVLA’s vehicle database did not identify the vehicle’s registered keeper, there was no evidence of such a search having been logged. The Council was also unable to provide the Ombudsman with evidence that it had issued a statutory notice informing the landowner of its intention to remove the vehicle. The Council was unable to say when the statutory notice had been issued and the landowner confirmed he had not received the statutory notice. Finally, the investigation found that, following the removal of the vehicle, Mr G was told by the Council and the car dismantler that the vehicle had been destroyed, although it was not destroyed until two weeks later.

The Ombudsman upheld the complaint since there was insufficient evidence that the Council had taken appropriate action to establish that Mr G’s vehicle had been abandoned and the Council had failed to follow the correct statutory procedure when issuing a statutory notice of its intention to remove and dispose of Mr G’s vehicle.

The Ombudsman upheld the complaint and recommended that the Council:

- a) Apologise to Mr G for the shortcomings identified in this report and provide him with redress of £2500 for the loss of his vehicle and its contents
- b) Provide further redress of £250 for his time and trouble in having to pursue the Council for an explanation of what had happened.

The Ombudsman also recommended that the Council should review and amend procedures within its service, to ensure that appropriate records are created, and that documentation is retained for all activity relating to the removal and disposal of vehicles under the relevant statutory regulations.

Aneurin Bevan University Health Board - Health - Clinical treatment in hospital

Case Number: 201704489 - Report issued in October

Mrs B complained about the care and treatment given to her son (“Mr C”), by the Podiatry Service and during two hospital admissions, when he suffered foot problems associated with diabetes. Mrs B said the Podiatry Service was inadequate, Mr C was discharged from his first admission too soon and the Health Board failed to provide adequate protection for Mr C against Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) following an operation to amputate an infected toe, during his second admission to hospital, and that this resulted in Mr C suffering a PE 12 days later, from which he sadly died.

The investigation found that earlier referral by the Podiatry Service to a specialist team might have resulted in earlier treatment of his condition and might have prevented the need to amputate Mr C’s toe. The investigation found that further steps should have been taken before Mr C was discharged

following his first hospital admission, and had these steps been taken Mr C's care might have been managed differently.

The investigation also found that Mr C was at increased risk of DVT/PE and that protection against DVT/PE should have continued after he was discharged from his second hospital admission. Had Mr C received medication to reduce the risk of DVT/PE it might have prevented Mr C from developing the PE which caused his death. It follows that Mr C's death might have been avoided.

[Cardiff and Vale University Health Board - Appointments/admissions/discharge and transfer procedures](#) [Case Number: 201701616 - Report issued in November](#)

Ms A was detained under the Mental Health Act ("the MHA") in Wales. In October 2015, she moved to a secure hospital ("the Hospital") in England. In March 2016, Ms A was discharged from detention. This meant she was free to leave the Hospital, but she agreed to remain there on a voluntary basis while aftercare and supported living accommodation were arranged to support her safe discharge into the community. Ms A remained in the Hospital until February 2017. Throughout, the Health Board remained the responsible body under the legislation to ensure Ms A's aftercare services were provided to her in a timely manner.

Ms A's Solicitor ("the Solicitor") complained about the Health Board's poor care after Ms A's discharge from detention. The Solicitor said that the Health Board failed and/or delayed in providing Ms A with aftercare, appropriate supported accommodation and a referral to the CMHT. In addition, the Solicitor complained that the Health Board failed to provide Ms A with mental health support and a safe environment during the time she remained at the Hospital as a voluntary patient. The Solicitor also complained about the Health Board's poor complaints handling.

My investigation found that the Health Board should have made the necessary aftercare arrangements with the English Trust before Ms A was discharged from detention. This contributed to the subsequent difficulties and delays.

However, the Health Board did make several referrals to the Community Mental Health Team in England ("the CMHT") to find a solution which would progress Ms A's reintroduction into the community. The CMHT did not accept Ms A's referral until May 2017, and her aftercare was not properly in place until November 2017. I found that despite the Health Board's attempts to resolve the issue, the main obstacle to progressing Ms A's discharge from the Hospital to a local supported environment was that the CMHT would not accept the referral from the Health Board until Ms A was registered with a local GP, was discharged from the Hospital, and had a local residential address. Ms A remained an inpatient at the Hospital for almost a year after her discharge from detention, on a locked rehabilitation ward with other patients detained under the MHA.

The Health Board acknowledged Ms A's experience was neither acceptable nor in line with its usual practice but said it could not resolve the issues with the CMHT. From February 2017, it continued to fund a full inpatient service from the Hospital, so Ms A could receive the appropriate care package to enable her to move to the flat she had found. I upheld Ms A's complaints.

I identified a need for cross-border health care guidance.

I have shared my report with the Welsh Government for it to review whether action needs to be taken at an all Wales level to reduce the risk of a similar situation arising. Ms A's human rights were also engaged as a result of the failures identified in my report. I recommended that the Health Board should:

- a) Provide Ms A with a fulsome and sincere apology from the Chief Executive for the failures identified
- b) Pay Ms A £500 in recognition of the poor handling of her complaint and the additional unnecessary frustration and disappointment she experienced as a result

- c) Refer Ms A's case to its Legal & Redress Team to consider appropriate financial redress in recognition of the distress caused to Ms A by the failures identified in this report and the unnecessary delays which compromised her right to a family life
- d) Refer my report to the Board and to the Health Board's Equalities and Human Rights team to identify how an individual's human rights can be further embedded into its practices and procedures in respect of mental health care
- e) Audit of a sample of patients discharged from compulsory detention to somewhere outside the Health Board's area to ensure that others have not been similarly disadvantaged. If the audit identifies any failures, the Health Board should detail the action taken and provide me with an appropriate action plan.

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

[Case Number: 201707515 - Report issued in November](#)

Mr W complained that the Health Board failed to provide appropriate wound care to his father, Mr R, when Mr R was discharged to a Community Hospital for rehabilitation following a total hip replacement. Mr W said that staff at the Community Hospital failed to identify, manage and treat his father's post-operative infection, or arrange for his transfer back to the District General Hospital, for treatment, appropriately. He said that, as a result of the failings in care, Mr R succumbed to further post-operative complications, developed hospital-acquired pneumonia, and sadly passed away.

The Ombudsman found that appropriate dressings were not used at any time throughout Mr R's care and his wound clips remained in situ throughout his admission, which was likely to have exacerbated his infection. In addition, there was no comprehensive review of Mr R or his wound by a doctor after the initial admission assessment, despite clear evidence that infection was present. Senior medical advice should have been sought promptly from the District General Hospital and the failure to do so delayed appropriate treatment for Mr R by at least a week, which made it more difficult to treat the infection, and for Mr R to fight it.

The Ombudsman also found that the Health Board failed to ensure that it had fully informed the Welsh Ambulance Services Trust of Mr R's condition, or that appropriate transport was arranged to transfer him back to the District General Hospital.

The Ombudsman recommended that, within one month of the date of his report the Health Board should:

- a) Apologise for the failings identified
- b) Offer Mr W £2000, in recognition of the service failures identified and the repercussions of those failings for Mr R
- c) Share the outcomes of this investigation with relevant staff in both the Community Hospital and the District General Hospital, highlighting the important learning points including early recognition of signs in the deteriorating patient, comprehensive record-keeping and the sharing of appropriately detailed hand-over information.

The Ombudsman also **recommended** that, within **three months** of the date of his report the Health Board should:

- a) Ensure that the Wound Management Guidelines are up to date and remind all staff of the properties/appropriate uses of the listed dressings.
- b) Undertake an audit to determine that all staff training on the Principles of Wound Management and the use of Aseptic Non-Touch Technique ("ANTT") for all wound dressing changes is up to date. Where training is not up to date, those staff members should be given training as soon as possible.

- c) Ensure that it has robust handover systems in place at both the District General Hospital and the Community Hospital for arranging patient transfers, to ensure that WAST is fully informed of the patient's condition when they are moved between settings.
- d) Provide evidence to the Ombudsman that the Health Board has adequate arrangements in place for senior medical review at the Community Hospital.

The **Health Board** agreed to implement these recommendations.

Health

Upheld

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

Case Number: 201702458 - Report issued in October

Mrs A complained about the Health Board's care and treatment in 2015/16 for a vaginal lump. Mrs A complained that the Health Board misdiagnosed the lump as an infected cyst which delayed her diagnosis and treatment for cancer; she also queried whether the clinical procedures were appropriate. Mrs A complained about a delay in reporting her biopsy results, and that she was discharged without the benefit of the biopsy result. Mrs A also complained about a lack of content in the Health Board's response to her concerns.

The Ombudsman's investigation found that based on Mrs A's presenting symptoms, the diagnosis of an infected cyst was reasonable and that the gynaecological procedures undertaken were appropriate. Mrs A disagreed with this view but based on the evidence provided this issue was not upheld. The investigation found there was a delay in Mrs A receiving her biopsy result and that she had not been properly informed about how her results would be relayed to her, or the expected timeframe. The evidence revealed that the delay had no significant clinical impact on Mrs A's prognosis, outcome or recovery but that the delay caused Mrs A distress and an element of uncertainty, which was an injustice to her. The complaints handling issue was upheld.

Recommendations were made to address the shortcomings identified including a written apology and financial redress payment.

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

Case Number: 201703015 - Report issued in October

Mrs Q complained about the overall care and treatment her father, Mr R, received between 25 and 29 May. Specifically, Mrs Q complained that the Health Board did not listen and act on her requests for Mr R to receive care from the Respiratory team earlier or move him to the Motor Neurone Disease team in a neighbouring Health Board; that Mr R suffered due to incorrect amounts of oxygen and fluids administered; and Mr R's care was not escalated when his NEWS indicated that it should.

The Ombudsman found that Mr R was moved to its specialist respiratory ward within 48 hours of admission, but contact from the neighbouring Health Board offering assistance was not communicated to Mrs Q. The Ombudsman also found that Mr R was administered incorrect amounts of oxygen and fluids that contributed to his distress: in particular, Mr R was not given non-invasive ventilation ("NIV") upon admission. The Ombudsman concluded that whilst he could not be absolutely certain, if Mr R had been given NIV his subsequent deterioration and cardiac arrest might have been prevented. The Ombudsman also found that Mr R's care was not escalated when his NEWS indicated it should have been, and Mr R's Do Not Attempt Cardiopulmonary Resuscitation form was not filled out in accordance with accepted guidance.

The Ombudsman upheld the complaint and recommended significant financial redress, further training for staff involved in Mr R's care, and for the Health Board to review its care of patients using NIV to ensure it is compliant with national guidelines.

[Hywel Dda University Health Board - Other](#)

Case Number: 201704398 - Report issued in October

Miss D complained about the care and treatment her father, Mr E, received just prior to his hospital admission on 15 May 2016 and up until his death on 27 May. In particular, Miss D was unhappy that an

oncology review failed to recognise that Mr E had an infection; an examination by an out-of-hours ("OOH") GP was inadequate; numerous dietetic referrals were not followed up and Mr E was never seen face-to-face by the Dietetics Team; and input by the Macmillan Lung Cancer Nurse Specialists was poor and they did not contact the family following Mr E's death.

The Ombudsman found that Mr E did not have an infection at the time of his oncology review, and overall the OOH GP examination was reasonable. However, the Ombudsman found that whilst it was reasonable that the Dietetics Team did not see Mr E face-to-face, it failed to keep a follow-up appointment and failed to contact Mr E again when a telephone call was cut off. Finally, the Ombudsman found that the input by the Macmillan Lung Cancer Nurse Specialists was reasonable, however, they failed to contact Miss D on the day Mr E died and subsequently. Although not part of the scope of the investigation, the Ombudsman also found that the Health Board failed to respond to part of Miss D's complaint.

The Ombudsman upheld the complaint in part and recommended an apology, a nominal amount of financial redress and process improvements.

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

[Case Number: 201707013 - Report issued in October](#)

Mr X suffers from idiopathic pulmonary fibrosis (a progressive condition resulting in scarring of the lungs). Mr X said that he moved to Wales after a visit led to improvements in his condition. In 2015 and 2016 Mr X had lung function tests and CT scans ("the tests") before appointments with the Respiratory Consultant. Mr X said that he always had the tests before consultations in his previous Health Board area. Mr X complained that appointments for the tests were not arranged after his appointment in October 2016 and that he had to pursue a consultation which was offered in July 2017, without having the tests for comparison to previous ones.

The Ombudsman partly upheld the complaint to the limited extent that it should have been explained to Mr X that the tests were not required before his July 2017 consultation. The Health Board had already apologised to Mr X for this shortcoming. The Ombudsman found that the tests were not medically required before an appointment and any delay had not exacerbated Mr X's condition.

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

[Case Number: 201704497 - Report issued in October](#)

Miss A complained about the care and treatment her grandmother Mrs M received at the Hywel Dda University Health Board's ("the Health Board") Emergency Department ("ED") of Bronglais Hospital ("the Hospital") on 16 December 2016. This followed a fall at home where she had suffered burns. Miss A raised concerns about her grandmother being transferred to a specialist burns unit ("the Burns Unit") outside the Health Board's area in a private hire taxi while dressed in her pyjamas. Miss A said that during the two hour journey her grandmother had vomited and on arrival at the Burns Unit she was diagnosed with a chest infection and prescribed antibiotics. This led to a delay in the skin grafting procedure being undertaken. Miss A also complained about the Health Board's poor complaint handling.

The Ombudsman concluded that broadly the care provided to Mrs M was reasonable. However, he was concerned that when there were clinical indications that Mrs M's condition had deteriorated her care was not escalated to a registered nurse or a clinician. This meant that Mrs M's clinical condition was not appropriately assessed before she was transferred in a taxi. He was of the view that had a review been undertaken this might have led to a change in the way she was transported to the Burns Unit. The Ombudsman noted that the Health Board had no alternative but to transfer Mrs M to the Burns Unit in a taxi, however, he found no evidence that this was appropriately communicated to Mrs M and upheld this aspect of the complaint.

In relation to Miss A's concerns about complaint handling the Ombudsman concluded that the Health Board's complaint response was inaccurate and caused Miss A distress and also upheld this part of Miss A's complaint.

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

[Case Number: 201704984 - Report issued in October](#)

Ms A complained about the care and treatment her late father Mr A received during his inpatient stay at Wrexham Maelor Hospital ("the Hospital") and the lack of respect shown to her and her family by the staff when visiting their father in the chapel of rest. Ms A also complained about the Health Board's handling of her complaint.

The Ombudsman found that the medical care provided to Mr A was reasonable and appropriate. However, investigation found some shortcomings in the nursing care that Mr A received which had been identified previously by the Health Board. Given the acknowledged shortcomings in nursing care it was to that extent only that Ms A's complaint was upheld. The Ombudsman recommended that the Health Board apologise to Ms A for the nursing failings identified and pay her the sum of £500 in recognition of the distress caused to Mr A and his family.

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

[Case Number: 201703419 - Report issued in October](#)

Mrs B complained about her care and treatment at an eye clinic appointment. She also complained that the clinic was not accessible to her which resulted in her consultation being carried out in the waiting room.

The Ombudsman found that, overall, the clinical care provided by the Consultant was broadly of an acceptable standard. He did not uphold this complaint.

The Ombudsman found that the clinic was accessible to Mrs B. That said, whilst it could not be proven beyond doubt that the consultation took place in the waiting room, the evidence was suggestive that the consultation, on the balance of probabilities, took place in the waiting room without consent. The Ombudsman upheld this complaint.

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

[Case Number: 201702101 - Report issued in October](#)

Ms A's wide-ranging complaint related primarily to various aspects of her clinical care and management by the Community Mental Health Team and the Dialectical Behavioural Therapy ("DBT") Therapist and inaccuracies/falsification of her medical records. She was also dissatisfied with the Health Board's handling of her complaint.

The Ombudsman's investigation concluded to varying degrees that Ms A's management and care was reasonable and did not uphold those parts of her complaint. The Ombudsman did find shortcomings in record keeping, although no evidence of falsification. He also found, as the Health Board had, inadequacies in complaint handling. The Ombudsman upheld to an extent those aspects of Ms A's complaint.

The Health Board agreed to apologise to Ms A for the failings identified and to make a redress payment of £250 for the shortcomings in complaint handling.

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

[Case Number: 201704172 - Report issued in October](#)

Ms A complained about the management of her pregnancy in 2016 by Abertawe Bro Morgannwg University Health Board's ("the Health Board") Princess of Wales Hospital. She was dissatisfied that her repeated requests for a caesarean section ("CS") were ignored, despite the concerns that she raised

about her two slipped discs in her back. She said that she had concerns about the impact a natural delivery would have on her back and complained that she had been left with life changing pregnancy related injuries. Ms A also complained about the Health Board's handling of her complaint.

The Ombudsman's investigation found no reference in the medical records to Ms A having requested a CS. He also concluded that Ms A's antenatal and labour management were in keeping with current practice in this area. He did not uphold this part of Ms A's complaint.

The Ombudsman identified some shortcomings around complaint handling. In particular that the Health Board could have been more robust in aspects of its complaint response. He also voiced concern about the fact that the date on the complaint response and the complaint management system did not appropriately reflect the date the response letter was sent out which was some weeks later. To that limited extent only he upheld this part of Ms A's complaint.

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

[Case Number: 201704358 - Report issued in October](#)

In 2016, Ms E's mother, Mrs C, aged 86, who had recently undergone a left knee replacement operation, fell at home and fractured her femur. A few days later she underwent an operation at Betsi Cadwaladr University Health Board's ("the Health Board") Ysbyty Glan Clwyd. Ms E and her mother were unhappy with the surgery and its impact on Mrs C's replacement knee and her subsequent loss of mobility. Mrs C subsequently underwent corrective surgery to try to restore her level of mobility.

The Ombudsman's investigation found evidence of poor record keeping, including a significant deviation from standard orthopaedic practice in carrying out the procedure, which was not documented. The Ombudsman also identified failings around the consenting process, for what was a complex procedure, as well as shortcomings in Mrs C's post-operative management. Additionally, the Ombudsman, noted that whilst he could not say that Mrs C might not have had some post-operative problems with her leg, he could not discount the probability that further corrective surgery could have been avoided. He upheld these parts of Ms E's complaint.

The Ombudsman's recommendations included the Health Board apologising to Ms E and her mother for the failings and carrying out an exercise analogous to the Putting Things Right process to arrive at a redress calculation. The Ombudsman also set out measures the Health Board should take to facilitate the learning of clinical lessons at a departmental and clinician level.

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

[Case Number: 201704648 - Report issued in October](#)

Mrs A complained about the appropriateness of the care and treatment she received from the Health Board for breast cancer between April 2014 and September 2016. In particular, Mrs A complained that there was a delay in diagnosing her breast cancer.

The Ombudsman's investigation found that the care and treatment Mrs A received between April 2014 and April 2015 was appropriate but that aspects of the care and treatment Mrs A received between May 2015 and September 2016 were not adequate. There was a failure to diagnose the cancer in Mrs A's right breast, inadequate diagnostic methods were used for the left breast and record keeping was poor.

The Ombudsman upheld Mrs A's complaint for the period between May 2015 and September 2016 to the extent that Mrs A was left with the uncertainty of not knowing whether her breast cancer could have been diagnosed earlier.

The Health Board agreed to apologise to Mrs A, provide her with a redress payment of £750, review its record keeping and provide evidence of the implementation of the Multidisciplinary Triple Diagnostic Method in patients with breast symptoms.

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

[Case Number: 201802636 - Report issued in October](#)

Ms X complained about the inpatient care given to her late partner, Mr Y, by Aneurin Bevan University Health Board ("the Health Board"). She expressed concern about a number of issues including the Health Board's management of Mr Y's falls risk. She also complained that the Health Board had not chased up its referral for a supplementary pathology report pertaining to sMr Y. She also indicated that she was concerned about the Health Board's response to her concerns about the loss of some of Mr Y's property.

The Ombudsman, having spoken to Ms X, asked the Health Board if it would be willing to resolve Ms X's complaint by:

- a) Local resolution meeting - Convening another local resolution meeting.
- b) Lost property letter - Writing to Ms X to clarify the current position regarding its response to her concerns about Mr Y's lost property.
- c) Further written response - Sending Ms X, after another local resolution meeting has been held, a further written response to her outstanding concerns, which addresses the issue of qualifying liability in accordance with the 'Putting Things Right' process.

The Health Board agreed to undertake these actions. The Ombudsman considered, as a consequence, that Ms X's complaint had been settled.

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

[Case Number: 201704795 - Report issued in October](#)

Mrs X complained to the Ombudsman about aspects of the care provided to her late mother (Mrs Y) whilst a patient at Ysbyty Gwynedd and subsequent care provided to her mother by district nurses following her discharge home.

Of particular concern to Mrs X was poor communication with Mrs Y's family and the discharge arrangements ward staff made for her mother. Mrs X was also concerned about the frequency of district nurses' visits to her mother, the lack of care planning and poor arrangements for transferring Mrs Y to a care home.

The Ombudsman found no evidence of any failings in the manner staff communicated with Mrs X regarding her mother. That said, shortcomings were identified in the manner in which clinical staff arranged Mrs Y's discharge home including a failure to make sufficiently early contact with district nursing staff. Shortcomings were also identified in relation to the actions of district nursing staff.

In particular there was no evidence of an agreed care plan to meet either Mrs Y's needs as a patient or Mrs X's needs as a carer. Poor communication and engagement with Mrs X and Mrs Y were also identified. The poor quality of record keeping also made it difficult for the Ombudsman to arrive at a definitive view about the quality of the care provided to Mrs Y. These elements of the complaint were upheld. Other shortcomings were identified, which by themselves, had not caused Mrs Y an injustice, but led the Ombudsman to invite the Health Board to consider further.

The Ombudsman recommended the Health Board apologise to Mrs X and to take action to review elements of its district nursing service including documentation, communication and the need to involve carers in the process. He also recommended the Health Board remind relevant hospital staff of the need for early engagement with district nursing staff to plan patient discharge.

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

Case Number: 201607390 and 201607392 - Report issued in October

Mrs A complained about the care and treatment provided to her late father, Mr B, by GPs at a Health Centre ("the Health Centre") in the area of the Health Board. Mrs A was concerned that the Health Centre did not carry out appropriate and timely investigations into Mr B's condition, and did not make an urgent referral to secondary care (care a patient receives in hospital, as either an in-patient or an outpatient), given the suspicion of cancer. Mrs A also complained about the treatment provided to Mr B at Ysbyty Alltwen Community Hospital ("the First Hospital"). Mrs A was also concerned that the First Hospital did not respond to the deterioration in Mr B's condition by escalating his care appropriately or considering transfer to Ysbyty Gwynedd ("the Second Hospital").

The Ombudsman found that Mr B was managed reasonably by GPs and there was no delay in referral to an appropriate specialist team when he displayed symptoms of possible cancer which was in line with NICE Cancer Referral Guidelines. The Ombudsman also found that there was no evidence to suggest that there was a requirement for an additional referral to the NHS following the private referral. These complaints were not upheld.

The Ombudsman found evidence of shortcomings at the First Hospital in the completion of the nursing care management tools and that standards of care fell below the level expected in several areas. There were also clear failings in the provision of proper hydration and nutrition for Mr B and the lack of ability to administer IV antibiotics. The Ombudsman determined that Mr B's condition had deteriorated during the period he was a patient at the First Hospital and that transfer back to the Second Hospital would have allowed him to have received care which was more appropriate to his needs. These elements of the complaint were upheld.

The Ombudsman's recommendations included that the Health Board write a letter of apology to Mrs A for the failings identified. He also requested evidence that it had carried out the recommendations in its own action plan which included training on nutrition and fluid balance and that it had a clear escalation plan in place if a patient deteriorates which should be discussed with both patient and family. A financial redress payment was also recommended; however, in accordance with the views of Mrs A, no financial redress is being made in this instance. The Health Board agreed to implement all of the recommendations made.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201706649 - Report issued in October

Mrs X complained about the care and treatment given to her late husband (Mr X) by the Health Board. In particular, Mrs X complained that opportunities were missed to diagnose Mr X's cardiac difficulties, subsequent prognosis and treatment options were not communicated to him and he was not provided with appropriate treatment and/or a care package to manage the symptoms associated with his cardiac diagnoses.

The investigation found that, whilst opportunities were missed by the Cardiac and Respiratory Teams to diagnose Mr X's cardiac difficulties, the investigations undertaken by the respective Teams were reasonable. Mr X was at least partly aware of his diagnosis. However, there was no evidence that Mr X was informed of his prognosis and/or treatment options. The treatment and management of Mr X from a cardiac perspective whilst an inpatient was reasonable, however the discharge plan was not.

The Health Board agreed to apologise to Mrs X for the shortcomings identified, to ensure that relevant staff undergo training on record keeping and to review its process for ensuring that planned follow ups with specialist clinics are documented within discharge reports.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201800086 - Report issued in December

Mrs A complained about the care and treatment provided for her late mother, Mrs B's, cancer. In particular, she was concerned that it should have been identified sooner that the cancer originated in Mrs B's colon, and been treated accordingly. Mrs A was also concerned about the standard of communication between the different specialties treating her mother, and with Mrs B and her family. Mrs A also complained about the handling of her complaint by the Health Board, in particular the time taken.

The Ombudsman did not uphold the complaint about the identification of the origin of Mrs B's cancer as this was a very unusual case and the origin of the cancer was in fact not clear. The Ombudsman found that there were some failures in communication between the different specialties, but he did not uphold that part of the complaint as the treatment given would not have been different had they not occurred. The Ombudsman upheld the part of the complaint about communication with Mrs B and her family, as this had increased Mrs B's concerns. He did not uphold the complaint about complaint handling. The Ombudsman recommended that the Health Board apologise to Mrs A, and provide a written reminder to the respiratory team of the need to ensure that if the origin of a cancer is uncertain, it needs to be reviewed by the relevant cancer multidisciplinary team.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201800924- Report issued in December

Mrs C complained that her then Consultant Ophthalmologist inappropriately changed her eye drops and refused to take her seriously when she complained of side effects. Mrs C said that she was forced to pay for a private consultation with a different Consultant, who changed her prescription. Mrs C said that the side effects subsequently stopped.

The Ombudsman found that the changes to Mrs C's eye drops were justified in the clinical circumstances. However, Mrs C should have been warned that she might experience side effects, particularly as she had experienced a reaction to eye drops containing preservative in the past.

The Ombudsman upheld the complaint to the extent that communication around potential side effects was less than acceptable. The Ombudsman recommended that the Health Board apologise to Mrs C and issue a written reminder to the ophthalmologists at the hospital concerned of the need to ensure patients are warned of reasonably likely side effects when prescribed different eye drops.

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

Case Number: 201706195- Report issued in December

Ms A complained about the care and treatment her late mother ("Mrs B") received following her admission to the short stay cardiac unit at Morriston Hospital. She said that following an angiogram her mother was discharged and sadly, died as a result of having a heart attack at home. Ms A said that her mother's medical records showed a discrepancy between the findings of the angiogram and what was set out in the post-mortem report.

Ms A also complained about the Health Board's poor communication and complaint handling. The Ombudsman's investigation found that overall the care provided to Mrs B was reasonable and appropriate and did not uphold this aspect of Ms A's complaint.

The Ombudsman found that the Health Board's complaint handling and communication with the family was reasonable and timely and that it had provided a detailed response to Ms A's complaint. He therefore did not uphold this part of Ms A's complaint.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201700199- Report issued in December

Mr A complained on behalf of the family about his late partner, Ms B's, management and care at the Princess of Wales Hospital in 2015. Ms B suffered significant weight loss and severe abdominal pain in the period leading up to her death. Ms B had her gall bladder removed on 30 July, but her condition continued to deteriorate. Ms B was admitted as an inpatient in September and died from bowel complications the following month. The family felt that Ms B's gall bladder operation had been a factor in her eventual death. They also felt that the Health Board had not acted in a timely manner and this had led to a delay in Ms B's final diagnosis.

The Ombudsman concluded that Ms B's gall bladder operation had not been a factor in her death. He did not uphold this part of Mr A's complaint.

The Ombudsman whilst recognising that chronic mesenteric ischaemia (where there is a narrowing or blockage of the arteries supplying blood to the bowel, usually due to a build-up of fatty deposits in the blood vessels as well as blood clots) which Ms B had was rare, nevertheless, he identified that there were missed opportunities for her condition to have been diagnosed sooner. The Ombudsman concluded that, but for the delays in diagnosis Ms B's outcome might have been different. The Ombudsman also identified communication failings. He therefore upheld this part of Mr A's complaint.

Amongst the recommendations the Ombudsman made was that the Health Board should apologise to the family and provide training to its clinicians.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201704400- Report issued in December

Mr B complained about the care and treatment his son, Mr A, received between 11 November and 2 December 2016. In particular, Mr B complained that Ysbyty Cwm Cynon Hospital ("the First Hospital") was not equipped to deal with his son's complex needs and that there was an avoidable loss of dignity in the last days of his son's life. He also complained that his son should not have been allowed to travel to a second hospital on 30 November for a treatment which did not go ahead.

The Ombudsman's investigation found that Mr A's general care was of an acceptable standard and therefore did not uphold the complaint that the First Hospital was not equipped to deal with Mr A's complex needs. The investigation also did not uphold the complaint that there had been an avoidable loss of dignity in the last days of Mr A's life.

The investigation found that although Mr A was involved in the decision to travel to a second hospital for treatment, there was a concerning lack of documentation to show that an adequate medical assessment had been carried out prior to transfer. Due to the uncertainty this caused, this aspect of Mr B's complaint was upheld.

The Health Board agreed to apologise to Mr B for the failings identified, to review the the documentation supplied with patients attending procedures on other sites and to review how patients are assessed prior to attending procedures on other sites.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201701509 - Report issued in December

Mr A complained that Betsi Cadwaladr University Health Board ("the Health Board") caused him to suffer a coma by allowing him to participate in an alcohol detoxification programme while he was taking buprenorphine. He also said that the Health Board failed to monitor his condition appropriately after his related admission to Wrexham Maelor Hospital.

The Ombudsman found that the combined effect of all Mr A's medication had probably caused his coma. He also determined that the Health Board had not ensured that the clinical risks associated with Mr A's alcohol detoxification ("detoxification") were proactively managed. He upheld the detoxification aspect of Mr A's complaint as a result. He did not uphold the monitoring part of Mr A's complaint. The Ombudsman recommended that the Health Board should apologise to Mr A and pay him £1,000. He advised it to revise its prescribing guidelines for inpatient detoxification. He recommended that it should review Mr A's care at the inpatient treatment unit concerned. He also advised it to prepare an action plan to address any issues identified because of that review. The Health Board agreed to implement these recommendations.

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

[Case Number: 201705304- Report issued in December](#)

Mr and Mrs P complained to the Ombudsman about the actions of the Health Board following the admission of their son, M, to hospital after he developed significant liver problems. They were concerned that following his admission to hospital a flawed blood test resulted in him wrongly diagnosed as having been poisoned with antifreeze. They question whether the care and management he received was appropriate following the false result.

They were concerned that there had been other failings in the care provided to their son including that he was inappropriately subject to fluid overload and that there had been a delay in transferring M to a specialist centre. Additionally, they were concerned that the Health Board had made an inappropriate referral to safeguarding services as a result of the flawed test result. Finally, Mr and Mrs P complained about issues relating to the Health Board's handling of their complaint.

The Ombudsman found there had avoidable errors that led staff to incorrectly conclude that M had been poisoned with antifreeze which amounted to service failure. He also found that, whilst the Health Board had been entitled to make the safeguarding referral, the information contained within the referral about M being poisoned with antifreeze had the potential to inappropriately influence the actions of safeguarding agencies. He upheld this part of the complaint.

The Ombudsman did not find any shortcomings in the medical management of M's care, nor did he consider the manner in which the Health Board responded to Mr and Mrs P's complaint to be unreasonable and therefore did not uphold these complaints.

The Ombudsman recommended the Health Board should apologise to Mr and Mrs P for the shortcomings identified and provide them with redress of £1500. He also recommended the Health Board undertake a series of measure to address shortcomings identified in the operation and management of the biochemistry laboratory involved in providing the false blood test result.

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

[Case Number: 201704249- Report issued in December](#)

Mrs M complained about the care and treatment provided to her father, Mr X, prior to his diagnosis with a malignant rectal tumour (when cancer cells form in the tissues of the rectum). Mrs M specifically complained that it was unreasonable that a colonoscopy (a procedure in which a flexible instrument is inserted through the anus in order to examine the colon) was not scheduled for Mr X, after his first consultation on 1 March 2017. Mrs M also complained that there was a delay in a follow up appointment which did not take place until the family had chased it up. Mrs M was also concerned that there were delays in the diagnostic process prior to Mr X being diagnosed with a malignant rectal tumour and further delays in Mr X receiving treatment following his diagnosis.

The Ombudsman found that the clinical management of Mr X was appropriate given his presenting symptoms. He found that appropriate investigations were carried out at the time and was satisfied that a

colonoscopy was not required to have been arranged sooner. This complaint was not upheld. The Ombudsman found that there had been a delay in arranging a follow up appointment for Mr X and that additional investigations should have been undertaken sooner, and a diagnosis given in a more timely manner. These elements of the complaint were upheld. In relation to Mrs M's concern that there were delays in Mr X receiving treatment following his diagnosis with a malignant rectal tumour, the Ombudsman did not consider there was an excessive delay in Mr X commencing treatment following his diagnosis and did not uphold this complaint.

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

[Case Number: 201704413- Report issued in December](#)

Mr M complained about the care and treatment provided to his father, Mr X, by Aneurin Bevan Health Board ("the Health Board") prior to his sad death on 29 September 2016. Mr M raised concerns that there was a failure to provide adequate treatment to Mr X and a delay in diagnosing cancer of the bladder. Mr M also complained there was a failure to adequately monitor Mr X's nutritional levels, a failure to provide adequate care needs and a failure to adequately monitor Mr X's pain management. Mr M also said that communication with the family was poor.

The Ombudsman found that Mr X had been diagnosed with an aggressive cancer and the prognosis was very poor. He found the clinical management of Mr X was appropriate and he did not uphold the complaint. The Ombudsman found that there was a failure to complete food intake charts properly, shortcomings in the nursing care provided, that it was impossible to determine whether medication had been administered to Mr X and information provided to the family about Mr X's condition was, at times, confusing and unhelpful. These elements of the complaints were upheld.

The Ombudsman recommended that the Health Board should apologise to Mr M and provide a financial redress of £1000 in recognition of the distress Mr X, Mr M and his family would have experienced as a result of the shortcomings identified. He also recommended that the Health Board should provide evidence that it had carried out the recommendations contained within its action plan following its own investigation into Mr M's complaint and that relevant ward staff are reminded about the importance of good communication with patients and family members.

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

[Case Number: 201706156 - Report issued in December](#)

An advocate complained on behalf of Ms M following an assault she suffered whilst in the garden of a ward at St Cadoc's Hospital ("the Hospital") on 23 May 2017. Ms M complained that the risks from the patient ("Patient A") who assaulted her were not managed. Ms M also complained that the assault could have been prevented had sufficient observations been carried out.

The Ombudsman found evidence that due to Ms M's behaviour towards other patients, there was an increase in the risk of harm to her from other patients due to her vulnerability which meant that she should have been placed on more frequent observations. There was no risk formulation and risk management plan carried out earlier during Ms M's admission and she remained on general observations. The Ombudsman found that the lack of review and then increasing Ms M's observations back to intermittent observations because of her vulnerability to harm from other patients was poor practice and the incident may possibly have been avoided or better managed through de-escalation or earlier staff intervention. The Ombudsman upheld the complaints.

The Health Board agreed to implement the recommendations to apologise to Ms M and provide her with a redress payment of £750 to reflect the service failures identified, provide training to all relevant ward staff, to review its policy relating to observation of patients and strengthen the sections on increasing and decreasing levels of observation.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201705961 - Report issued in December

Mrs X complained about the standard of care provided to her late husband (Mr X) by the Consultant in Respiratory Medicine ("the Consultant") and clinicians based within the Cardiothoracic Surgical Services. The investigation found that there was a missed opportunity for an earlier diagnosis of mesothelioma. Furthermore, the Consultant did not insert an indwelling pleural catheter as planned.

Mr X was not diagnosed with mesothelioma until June 2016, however, it had been treated as the working diagnosis since August 2014. Save for a documented discussion in August 2014, there was no evidence that Mr X was told of the continued possibility of malignancy.

The intervention of the Cardiothoracic Surgical Services and Respiratory Team during Mr X's admission in 2016 was timely and the advice provided and overall communication was reasonable.

The Health Board agreed to apologise to Mrs X for the failings identified and make a redress payment of £2,500. In addition, it agreed to provide evidence that a copy of the final report had been circulated to all members of the Lung Cancer Multidisciplinary Team and that the members had been reminded of the importance of adhering to British Thoracic Society Guidelines.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201703698- Report issued in December

Miss P complained about the care and treatment she received at Wwithybush Hospital in January 2016, when she attended with bleeding during early pregnancy. Miss P specifically complained that communication with her about the potential outcomes of a speculum examination was poor and that the Specialist who carried out the examination aborted her baby by removing it from her cervix. Additionally, Mrs P had concerns about how her complaint was handled by the Health Board.

The Ombudsman found that there was a lack of evidence that an appropriate consent process had been followed and that it had not been fully explained to Miss P what the examination was for or what was happening during the procedure. This service failure caused Miss P acute distress when she was later presented with the tissue that had been removed in a jar. This element of her complaint was upheld, and the Health Board agreed to apologise to Miss P for this breakdown in communication and make a redress payment of £500.

The Ombudsman also found that, considering Miss P's presenting symptoms, an examination had been the appropriate course of clinical action and that Miss P's concern, that the Specialist had aborted her baby, was unfounded. These complaints were not upheld.

Finally, the Ombudsman did not identify any concerns about how Miss P's complaint had been handled by the Health Board and did not uphold this complaint.

Abertawe Bro Morgannwg University Health Board - Other

Case Number: 201704536 - Report issued in December

Mrs P complained that the care and treatment she received at the Princess of Wales Hospital when she was diagnosed with an ectopic pregnancy was not adequate. She specifically complained that communication with her throughout her treatment was poor and that earlier surgery may have prevented her fallopian tube from being removed.

The Ombudsman found that the Health Board could have monitored Mrs P more closely during her treatment and that, whilst Mrs P was informed of the different treatment options available for ectopic pregnancy, she was not told that the choice of treatment was her own. However, the Ombudsman was unable to use the benefit of hindsight to say that Mrs P would have chosen surgery if it had been offered to her earlier, and was satisfied that, at whatever stage Mrs P had surgery, her fallopian tube would still

have been removed. This element of Mrs P's complaint was partially upheld and the Health Board agreed to apologise and make a £1000 redress payment to Mrs P for the distress caused by these failings. The Health Board also agreed that the clinicians involved in Mrs P's care would discuss her case at their next review meetings.

Mrs P also complained about how her complaint had been dealt with by the Health Board. The Ombudsman found that there had been errors in the handling of Mrs P's concern and this element of her complaint was also partially upheld. The Health Board agreed to the recommendations made which were an apology and a £250 redress payment for Mrs P.

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

[Case Number: 201707286- Report issued in December](#)

Ms C complained about the treatment given to her late mother, Ms B, when she suffered a stroke. She said there was an unreasonable delay in a doctor attending to Ms B, Ms B's care and treatment were compromised by clinicians and nursing staff confusing Ms B with other patients on the ward and Ms B's call button was not readily available when it was needed.

The Ombudsman found the care Ms B received overall was good and in line with stroke guidance. There was an unreasonable delay in attending to Ms B but it was not possible to say that the delay had negatively impacted on her care, therefore this element of the complaint was upheld, but only to a limited extent. The Ombudsman found that notes had been incorrectly placed on Ms B's records but they did not affect the care that was given and that Health Board has now taken measures to address concerns about the availability of call buttons. The Health Board agreed to apologise to Ms C for the delay in reviewing Ms B. It also agreed to ensure there is a process in place to hand over the care of patients, on the specialist stroke ward, to the on-call consultant when the stroke specialist consultant is not available.

Not upheld

[A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital](#)

[Case Number: 201706959 - Report issued in October](#)

Ms J complained about her contact with the GP Practice. In particular she said it failed to offer her an emergency appointment, provide appropriate medication and take timely action to investigate and diagnose an eye condition which resulted in vision loss.

The Ombudsman found that it was reasonable of the GP Practice to not offer Ms J an emergency appointment based on her presenting symptoms. The Ombudsman also found that appropriate medication was prescribed by the two GPs who saw Ms J. Additionally, the Ombudsman was satisfied Ms J's eye condition could not have been diagnosed by either GP as her symptoms were subtle and did not change significantly until after her second appointment and prior to her third appointment, following which a diagnosis was made. The Ombudsman did not uphold the complaints.

However, the Ombudsman did have some concerns about some aspects of the consultations conducted by the two GPs and invited the GP Practice to consider his comments.

[Cwm Taf University Health Board - Appointments/admissions/discharge and transfer procedures](#)

[Case Number: 201703682 - Report issued in October](#)

Mr X was 83 years old, he had advanced dementia, atrial fibrillation (irregular rapid heartbeats) and a long-term urinary catheter fitted. Mr X was bed bound, he had difficulty in swallowing and was prone to aspiration pneumonia (inhaling food, liquid or vomit into the lungs). On 4 December 2016, Mr X was admitted to Hospital with dehydration. Mr Y complained on behalf of his sister about her husband Mr X's treatment and discharge from hospital on 9 December 2016, as he was readmitted later that same day having collapsed suffering from a cardiac arrest.

The Ombudsman had no criticism of Mr X's treatment or discharge. The Ombudsman invited the Health Board to consider learning from Mr X's ward round entry being untimed and that conversations with Mrs X about his discharge should have been recorded.

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

[Case Number: 201706994 - Report issued in October](#)

Mrs K complained that, between 8 February **2016** and April **2017**, Cardiff and Vale University Health Board ("the Health Board") failed to appropriately investigate, diagnose and treat her granulomatosis with polyangiitis (a rare disease in which a build-up of white blood cells causes inflammation in the blood vessels of the nose, sinuses, ears, lungs and kidneys and can damage organs).

The Ombudsman found that Mrs K's symptoms in February and April **2016** were consistent with infection and, therefore, it was reasonable to treat them as such. Notwithstanding that the events, as they occurred, meant that Mrs K remained in ignorance of her diagnosis, and that this was distressing to her, it did not appear that there had been any material affect on her condition, or her care plan as a consequence of the Health Board's decision to prescribe antibiotics initially. Furthermore, the prescription of antibiotics, and their inefficacy, informed the diagnostic process and therefore did not represent a deficiency within it or inordinately delay the ultimate diagnosis.

The Ombudsman also found that Mrs K's care plan and treatment was reasonable and in line with appropriate, applicable guidelines. Accordingly, he could not find that there was any deficiency in the care provided by the Health Board and he **did not uphold** the complaint.

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

[Case Number: 201800927 - Report issued in October](#)

Mr L complained that, following an urgent referral in Autumn 2017, the Community Mental Health Team at Cardiff and Vale University Health Board ("the CMHT") did not act in line with NICE guidelines or person-centred care when it assessed him, that communication was poor and that he was inappropriately discharged from the service without access to secondary mental health services.

The Ombudsman found that the initial assessment was appropriate and carried out to an acceptable standard; it was appropriate that Mr L should have been referred to Primary Mental Health Services for the symptoms he was suffering and the discharge care planning was appropriate. Whilst the CMHT had identified some shortcomings in its communications with Mr L, these had not materially affected the clinical outcome of the assessment and the remedial action already taken by the CMHT was sufficient to put those things right. The Ombudsman **did not uphold** the complaint.

[A GP Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#)

[Case Number: 201706948 - Report issued in October](#)

Mr A complained that when a GP attended his wife, Mrs B, during a home visit, her condition was such, that he should have referred her to hospital and should have carried out a Glasgow Coma Scale assessment (assessment of impairment of consciousness level in a patient). Mrs B was admitted to hospital the following day and was found to have suffered a stroke and died soon after. Mr A considers that had the GP referred Mrs B to hospital, this may have altered the sad outcome.

The Ombudsman found that the clinical care provided by the GP was of an acceptable standard and that hospital admission was not indicated based on Mrs B's presentation during the home visit. He did not uphold the complaint.

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

[Case Number: 201706498 - Report issued in October](#)

Mrs J complained about the delay in carrying out knee replacement surgery, including the refusal of the Health Board to refer her to a neighbouring Trust for treatment. Although the surgery was not carried out

within the Referral to Treatment Time target set by the Welsh Government, the Ombudsman did not consider that, in itself, to be evidence of a service failure. He found that Mrs J's surgery should not have been classed as urgent, and that she did not meet the Health Board's criteria for referral to another Trust. The Ombudsman did not uphold the complaint.

[A GP practice in the area of Cwm Taf University Health Board - Clinical treatment outside hospital](#) [Case Number: 201704442 - Report issued in October](#)

Ms A complained about the care given to her late father, Mr B, by a GP practice in the area of Cwm Taf University Health Board ("the Practice"). She contended that the Practice had delayed the diagnosis of Mr B's liver cancer because it had not investigated his abdominal pain properly. She also argued that it had adversely affected the treatment of Mr B's heart failure and cancer because it had failed to respond to his leg swelling appropriately. She reported that the Practice had also refused to give Mr B appointments at the Practice.

The Ombudsman found that the Practice had investigated Mr B's abdominal pain correctly. He also determined that its response to Mr B's leg swelling had been fitting. He did not uphold the clinical care aspect of Ms A's complaint. The Ombudsman found that the Practice had refused to give Mr B appointments on three occasions. However, he could not determine that those appointment refusals were clinically unreasonable or that they necessarily warranted criticism. He did not uphold the appointment provision part of Ms A's complaint.

[Welsh Ambulance Services NHS Trust - Clinical treatment outside hospital](#) [Case Number: 201705592 - Report issued in October](#)

Mrs X complained that there was an unreasonable delay by Welsh Ambulance Services NHS Trust

("WAST") in attending to her mother, Mrs Y, on 15 December **2016**. She also complained that the Community First Responder ("CFR") who attended to Mrs Y did not give WAST's call handlers enough notice that his portable oxygen supply was running low.

The Ombudsman found that while there were procedural errors in the categorisation of some of the calls made in relation to Mrs Y's condition, ultimately these would not have impacted on the time it took for the emergency vehicle to arrive at Mrs Y's home. This was because, as it transpired, the first available vehicle was dispatched to Mrs Y and there was no other vehicle that could have been dispatched earlier.

The Ombudsman also found that there was no requirement for the CFR to inform WAST's call handlers of low oxygen levels in his cylinder (although WAST acknowledged that it would have been best practice and the CFR was reminded of this). As there was no other resource available to attend to Mrs Y it was concluded that, even if the call handlers had been made aware of the low levels of oxygen in the cylinder, there would have been nothing else that could have been done. The complaints were not upheld.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201704146 - Report issued in October](#)

Ms M complained on behalf of her and her sister, Ms L, that there was a delay in discharging their father, Mr A, from hospital. Mr A sadly died in hospital on 23 June 2017 despite his wishes to die at home. Ms M also raised concerns about poor communication between hospital staff and the family about Mr A's condition and his discharge, and as a result, they were denied the opportunity of being with him when he died.

The Ombudsman found that consideration was given to Mr A's wishes throughout his stay, and positive action was being taken to ensure his safe discharge home. It was clear that, throughout the period that Mr A was in hospital, both Ms M and Ms L were advocating for their father's wishes; however, it was unfortunate that a sudden deterioration on the 23 June meant that Mr A died more quickly and sooner

than had been expected and no opportunities had arisen in which Mr A could have been discharged home. The Ombudsman found that communication between clinical staff and Ms M and Ms L was reasonable.

There was clear evidence in the medical notes of regular conversations to discuss Mr A's condition, limitations of treatment, assessment of his care needs and the plan for future care and his discharge home. The rapid deterioration in Mr A's condition on 23 June prevented Ms M and Ms L the opportunity to travel to be with Mr A when he died, and the Ombudsman recognised the distress this must have caused to them. There was no evidence to suggest that Mr A's sudden deterioration could have been foreseen. The complaints were not upheld.

[A GP at a Practice in the area of Hywel Dda University Health Board - Clinical treatment outside hospital](#) Case Number: 201801478 - Report issued in October

Mrs Y complained that she did not receive reasonable care and treatment in relation to her neck spasm from the GP.

The complaint was not upheld. The Ombudsman concluded that overall the GP had acted reasonably in the care and treatment of Mrs Y's symptoms. However, the Ombudsman recognised that there was no record that Mrs Y had been warned of potential risks associated with her neck pain. He therefore asked for this to be reflected upon.

[A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital](#) Case Number: 201704558 - Report issued in October

Mrs B complained that A GP Practice in the area of Aneurin Bevan University Health Board ("the Practice") took too long to refer her son, Mr C to the podiatry service and during that time did not provide adequate treatment.

The investigation found that Mr C had direct access to the podiatry service and it was reasonable that the Practice issued antibiotics on behalf of the podiatrist. However, when Mr C did see a doctor at the Practice, he should have been referred to the hospital as he had not responded to antibiotic treatment, this did not happen. Mr C was urgently referred three days later when he returned to the Practice, therefore the minor delay did not impact Mr C's overall care so the complaint was not upheld.

[Cardiff and Vale University Health Board - Appointments/admissions/discharge and transfer procedures](#) Case Number: 201702970 - Report issued in October

Mrs X suffered a salmonella (bacterial) infection while in hospital, recovering from surgery to remove a brain tumour. She complained that she was inappropriately discharged home with oral antibiotics instead of being kept in hospital on intravenous antibiotics. She complained that the surgical follow-up arrangements had been inadequate.

Mrs X required another operation to insert a titanium plate where a piece of her skull had been removed. She complained that she was told that this would be done within three months of the operation to remove the piece of skull. The operation was eventually undertaken approximately nine months later.

The investigation found that the decision to discharge Mrs X with oral antibiotics was appropriate and that the surgical follow-up had been reasonable. The investigation found that the time that Mrs X had to wait for the operation to insert the titanium plate was not unreasonable, in the circumstances. The complaints were **not upheld**.

[Hywel Dda University Health Board - Clinical treatment in hospital](#) Case Number: 201705392 - Report issued in November

Mrs A complained about the care and treatment provided by the Health Board to her late uncle, Mr B, between 7 May and 24 August 2015. Mrs A specifically complained that the Health Board failed to

properly investigate Mr B's symptoms, failed to identify/diagnose his lung cancer in a timely way which led to his cancer spreading to other parts of his body, and it missed the opportunity to treat his cancer earlier. Mr B suffered with mental health issues and Mrs A complained that despite clinicians being fully aware of his hunger strike, no safeguarding procedures were instigated.

The investigation found that during the period complained about, apart from Mr B's inpatient stay from 6 August 2015 until his death on 24 August 2015, the Health Board was only involved in his care on two prior occasions. Based on the information provided, no evidence was found to suggest that there were any significant shortcomings in the care Mr B received, he was treated appropriately based on his presenting symptoms, and the first indication of his lung cancer was revealed on his chest X-ray on 7 August 2015.

Clearly, Mr B's mental health deteriorated during the period complained about, but there was no evidence that this was caused by any failings on the Health Board's part. Accordingly, Mrs A's complaints were not upheld.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201707275 - Report issued in November](#)

Mrs A complained about a number of aspects of the care and treatment provided to her husband, Mr A, by Betsi Cadwaladr University Health Board ("the Health Board"). Firstly, Mrs A said that those caring for her husband made an incorrect diagnosis in 2014 when he presented with bladder problems and then failed to review him within a reasonable timeframe. Additionally Mrs A complained that when he was later diagnosed with bladder cancer that he was not offered radiotherapy treatment as an alternative to surgery. Mrs A also expressed concern about the management of his treatment post surgery and conflicting messages about disease progression.

Following investigation the Ombudsman did not uphold any of Mrs A's complaints. He found that the diagnosis made in 2014 was appropriate based on the symptoms experienced at the time. Although the Health Board failed to complete a timely review of Mr A following this diagnosis no evidence was identified which would suggest that Mr A experienced symptoms which may have led to investigations and an earlier diagnosis during this period.

Whilst noting Mr & Mrs A's disagreement, the Ombudsman was satisfied that a number of treatment options, including radiotherapy, were appropriately discussed with them as an alternative to surgery. He found also that the post operative plan for Mr A was appropriate and in line with relevant guidance. He noted also that although conflicting messages may have been given following surgery however he was satisfied that communication had improved and encouraged the Health Board to continue in this way.

[Betsi Cadwaladr University Health Board & Flintshire County Council - Clinical treatment in hospital](#) [Case Number: 201704885 & 201704894 - Report issued in November](#)

Ms X complained on behalf of the family of Mrs H, in relation to the care and treatment she received from the Health Board and a safeguarding investigation carried out by the Council. In particular Ms X was unhappy with the care provided to Mrs H at a Care Home prior to her being admitted to Glan Clwyd Hospital ("the Hospital"), and the Health Board's actions in relation to the Council's adult safeguarding enquiries following a referral by staff at the Hospital. Ms X was also unhappy with the Council's failure to fully consider the referral in relation to Mrs H and carry out a thorough safeguarding investigation.

The Ombudsman's investigation found that the care and treatment provided by the Health Board was appropriate, as were the Hospital's actions in relation to the Council's adult safeguarding investigation.

However, the Ombudsman found that the Council's Adult Safeguarding Manager accepted broad assurances by the Health Board about the care given to Mrs H at the Care Home and did not consider

making his own enquiries. The Ombudsman also found that other avenues of enquiry were not followed up and a complete picture of Mrs H's care was not revealed before the investigation was closed.

The Ombudsman upheld the complaint against the Council and recommended an apology, and for the Council to review Mrs H's Care Home records to determine if the care she received at the time was appropriate.

[Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures](#) Case Number: 201800722 - Report issued in November

Mr D complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to communicate with him regarding an eye operation, which led him to pay privately for treatment.

The Ombudsman found that the Health Board had transferred Mr D's care to a hospital ("the Hospital") in England as part of an initiative to manage and reduce waiting times for ophthalmology patients in North Wales. Following successful cataract surgery on Mr D's right eye, he was told by the Hospital he required further surgery on his left eye. The investigation found that Mr D was then discharged appropriately as per the terms and conditions of the initiative. When Mr D contacted the Health Board just over two months later to find out when he would undergo cataract surgery on his left eye, he was told, correctly, that he would need to be re-referred and the waiting time was approximately 12 months. Rather than wait, Mr D sought treatment privately and underwent successful cataract surgery on his left eye. Shortly afterwards, the Hospital contacted Mr D and informed him that it was ready to go ahead with cataract surgery on his left eye following an extension of the initiative with the Health Board.

The Ombudsman found that the decision to go private was Mr D's, and not due to any obvious maladministration on the part of the Health Board. The Ombudsman did not uphold the complaint.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201706860 - Report issued in November

In **2014**, Mr X was found to have a high grade, muscle invasive tumour, that led to a radical cystectomy (the removal of the bladder) and he had a right sided urostomy (a procedure to create an opening through the skin for urine discharge). Mrs X complained about her late husband Mr X's **2016** treatments of his genital discharge, his care after he fell in February and about whether his referral to Oncology had been timely.

The Ombudsman found that when Mr X complained of a white discharge from his penis, he had timely, progressive urethral examinations and a request for an MRI scan, there were no significant delays or missed opportunities to have identified Mr X's recurring cancer sooner. He also found that there were no clinical records that Mr X complained of a fall and that the bony erosion identified by MRI scan on his sacrum (the triangular bone at the base of the spine) was an insufficiency fracture (a stress fracture which is the result of normal stresses on abnormal bone). The Ombudsman also found that Mr X's referral to Oncology was timely. He did not uphold the complaint. Betsi Cadwaladr University Health Board.

[Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#) Case Number: 201705807 - Report issued in November

Mr X complained about his GP healthcare in HMP Berwyn ("the Prison"). In particular, that the Health Board failed to assess his level of pain properly and prescribe appropriate medication, following an accident in which he injured his knee.

The Ombudsman found that it was appropriate for the Health Board to review Mr X's condition and medication prescription on his arrival at the prison, and that he was offered appropriate non-sedative pain relief as well as physiotherapy. Appropriate input was requested from the hospital Trauma and Orthopaedic ("T&O") Department, and an in-house X-ray was arranged. Whilst the Physiotherapists notes

were brief and it appeared that the lines of communication between the Prison GPs, the Prison physiotherapists and the hospital T&O Department were not as effective or robust as they could have been, these shortcomings did not result in a significant service failure in the management of Mr X's pain. The physiotherapy Care Plan was appropriate and there was no evidence that Mr X's referral or input from the T&O Department was, materially, delayed.

The Ombudsman did not uphold the complaint. However, he invited the Health Board to remind the Prison Physiotherapists of the following: firstly, the importance of maintaining full and accurate records, to ensure that the referral processes within the Prison are effective and efficient, and secondly, the importance of providing clear feedback to the referring clinician with the option of seeking specialist opinion to strengthen the decision-making process.

[Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#) [Case Number: 201707353 - Report issued in November](#)

Mr C complained about changes to his medication introduced since he became a prisoner at HMP Berwyn in September 2017. He also complained about the attitude of Health Board staff at the prison.

The Ombudsman found that the changes made to Mr C's medication – specifically the reduction and stopping of a prescription for pregabalin – were clinically appropriate. The Ombudsman found that there was insufficient evidence to conclude that the attitude of the staff members was inappropriate. He did not uphold the complaints.

[Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#) [Case Number: 201706406 - Report issued in November](#)

Mrs A complained about the care provided by the GP Practice for her late mother, Ms B. She said that the GPs failed to respond appropriately to Ms B's upper gastric symptoms and that this delayed the diagnosis of her oesophageal cancer, leading to her premature death in April 2017.

The Ombudsman found that the GPs initial management of Ms B's symptoms with medication when she first presented at the Practice in June 2016 was reasonable and in line with clinical guidance. Although Ms B was advised to re-attend if her symptoms did not resolve, she did not present for review of her symptoms until November 2016. The Health Board, who carried out a complaint investigation on behalf of the Practice, had already identified learning points in relation to repeat prescribing and weighing of patients with gastrointestinal symptoms. However, neither shortcoming materially affected the sad outcome. Accordingly, the complaint was not upheld.

[Hywel Dda University Health Board - Continuing care](#) [Case Number: 201706026 - Report issued in November](#)

Mr A complained about the Independent Review Panel's ("IRP") decision of 26 July 2017, not to award his father retrospective NHS funded continuing health care for the periods covering 17 September 2008 – 6 November 2014. He complained that the IRP's consideration was flawed as it did not have access to all the relevant facts and history of the case and did not properly consider relevant information and guidance in arriving at its decision.

The Ombudsman did not uphold Mr A's complaint. He was not persuaded on the evidence considered that the IRP's decision-making was flawed or that there had been any procedural shortcomings that affected the decision-making process.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201800723 - Report issued in November](#)

Mr A complained about the care that he had received at the University Hospital of Wales' Emergency Department ("ED"). Mr A, who felt he had been displaying symptoms of a pulmonary

embolism (a blood clot in the lungs), did not consider that it had been reasonable for him to have been discharged without being reviewed by a doctor or further tests being carried out.

The Ombudsman's investigation concluded that the care Mr A received was reasonable and therefore did not uphold Mr A's complaint.

GP Practice in the area of Powys Teaching Health Board - Clinical treatment outside hospital Case Number: 201704021- Report issued in November

Mrs A complained to the Ombudsman that, between April and June 2017, GPs at a GP Practice in the area of Powys Teaching Health Board ("the Practice") failed to adequately investigate and/or treat her presenting symptoms. Mrs A complained that GPs did not take her abdominal, chest and back pain seriously and failed, or improperly declined, to arrange appropriate tests, scans and other investigations (including admission to hospital) to determine her diagnosis. Mrs A also complained that it was inappropriate and offensive of GPs to suggest to her that, in the absence of a unifying diagnosis, she may be suffering from Medically Unexplained Symptoms (MUS) and that she should consider having this investigated via a psychological assessment.

The Ombudsman found that:

- a) GPs recorded in considerable detail Mrs A's presentations to the Practice, together with the many symptoms she presented with
- b) GPs prescribed appropriate medication for Mrs A and made arrangements for her to undergo relevant tests, scans and clinical investigations
- c) GPs conducted appropriate visits to Mrs A's home and made appropriate referrals to relevant clinicians
- d) GPs considered appropriate alternative diagnoses, including MUS, and tried to explain this condition to her in a sensitive way.

Consequently, the Ombudsman **did not uphold** Mrs A's complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201707946 - Report issued in November

Mrs A complained about the care and treatment provided to her late husband, Mr A during his hospital admission between 8 August and 9 September 2017. Mrs A complained that Mr A was not prescribed and administered with appropriate doses of insulin and diuretic therapy in line with previous management plans, which accelerated his decline in health. In addition, Mrs A complained that Mr A was not prescribed and administered with adequate pain relief.

The investigation found that Mr A was correctly managed as far as his diabetes and pain were concerned. The fluid retention that Mr A suffered from was a direct consequence of heart failure, which was managed appropriately. The evidence did not support Mrs A's assertion that Mr A's diuretic medication was inappropriately stopped during his admission. The clinical records clearly evidenced that clinicians interchanged IV and oral diuretic medication, in an attempt to treat Mr A, however sadly this was to no avail. The prescription and administration of diuretic therapy was reasonable. Therefore, based on all the available evidence, the Ombudsman found no basis to criticise the care and treatment of Mr A during his admission.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number: 201705956 - Report issued in November

Ms X complained about the standard of care and treatment provided to her by the Health Board when multiple teeth were extracted in September 2017. Ms X was aggrieved that, following her oral surgery, she was left in extreme pain and unable to use dentures. She was concerned that the surgery had caused her to suffer ongoing jaw pain, constant uncomfortable jaw-clicking and a

flutter and partial sightedness in her left eye. She said there was also a failure, during that operation, to notice that part of a tooth (a root) had been left in her gum, causing problems which required further surgery.

The investigation found that the procedure appeared to have been undertaken to an acceptable standard, even though one root was unfortunately missed during the surgery. There was no evidence that the pain resulting from the extractions, or the inability to use dentures, was a result of unacceptable or poor care on the part of the oral surgeons and there was evidence that the clicking jaw was present before the procedure was undertaken. Furthermore, there was no persuasive evidence that the issues relating to Ms X's eye had resulted from the surgery in September or had been caused by poor practice on the part of the clinicians involved in her care. Finally, the failure to notice and extract the submerged root was unfortunate but did not mean that the care had fallen below a reasonable standard.

Ms X's complaints were **not upheld**.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) Case Number: 201802427- Report issued in December

Mrs P complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to assess and treat her severe pain appropriately, when she attended hospital on 2 and 9 October 2017. Mrs P was concerned that the Health Board had missed a significant underlying problem, which precipitated her suffering a fracture in her femur (thigh bone) on 26 October, and she was worried that it might happen again.

The Ombudsman found that there was no failure by the Health Board in relation to the assessment and investigation of Mrs P's pain or the advice offered to her on either occasion, and that there had been no evidence that she was at risk of suffering a fracture, or of any underlying pathology (disease or abnormality). He **did not uphold** the complaint.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) Case Number: 201703363 - Report issued in December

Mrs X complained about the management of her husband's cardiac condition in October/November 2016 when he was a patient at University Hospital of Wales ("the Hospital"). She considered that there was an unreasonable delay in undertaking an operation to address the issue. Mrs X was also aggrieved about how the rash on her husband's foot was managed. She said the rash was never properly diagnosed or treated. Mrs X was concerned that her husband's chest infection and pneumonia were not managed properly.

The investigation found that there was a considerable delay from when it was decided that a TAVI procedure (Transcatheter Aortic Valve Implantation - a minimally invasive, catheter-based procedure to replace the aortic valve, introduced in the UK in 2007) would be the appropriate intervention, to the date when that was due to be undertaken. The investigation could not find that it was unreasonable or unacceptable, in the circumstances, that the TAVI procedure was not available sooner for Mr X or that the clinicians responsible for his care should have considered an alternative treatment approach.

The investigation found that the care provided by the dermatology service in respect of the rash was appropriate. Similarly, the response by the clinicians to Mr X's presumed chest infection was prompt and the treatment appropriate.

The complaints were **not upheld**.

Early Resolution or Voluntary Settlement

Cwm Taf University Health Board – Medical records/standards of record-keeping

Case Number: 201802963 - Report issued in October

In February 2018, Mrs J's husband was admitted to hospital with severe pains in his stomach. The following morning, he passed away. Mrs J was told by a doctor that Mr J had cancer which had spread to the bowel.

In replying to Mrs J's complaint, the Health Board said the cause of death was ischemic bowel, however the death certificate named the only cause of death as metastatic lung cancer.

The Ombudsman found that although the Health Board responded to Mrs J's initial complaint, her concern about this contradictory information was not addressed.

The Health Board agreed to undertake the following action, on receipt of the Ombudsman's decision, in settlement of the complaint:

- a) Issue a formal response to Mrs J's new concern within 6 weeks.

Oasis Dental Care Canton - Clinical treatment outside hospital

Case Number: 201803401 - Report issued in October

Mr S complained that the Surgery had failed to provide him with an emergency appointment when he had contacted it by telephone in May 2018. He was allocated an appointment in early June and was unhappy that the Dentist who examined him failed to deal with his dental problem at that time as insufficient time had been allocated. It transpired that Mr S had to have emergency private treatment some days later, whilst on a training course in London.

Mr S also complained that the Surgery had failed to respond to his complaint, which he made to it on 13 June 2018.

The Ombudsman contacted the Surgery and established that the Dentist had moved to live and work in another country.

The Surgery agreed to provide the complainant with

- a) A letter from the Dentist's Medical and Dental Defence Union ("the MDDUS"). A body that assists with patient complaints and will respond on his behalf.
- b) A letter from the Surgery apologising for the delay in responding to him and providing him with a response to the part of his complaint regarding its allocation of appointments.
- c) It has agreed to provide these within 20 working days of the date of this decision letter.

The Ombudsman believes that this provides a reasonable resolution to the complaint.

GP Practice in the area of Cardiff and Vale University Health Board - Other

Case Number: 201707457 - Report issued in October

Mr A complained about the care and treatment provided to his late brother, Mr B, by one of the GPs at the Practice. Mr B was profoundly deaf and had difficulty with communication. On the day his brother attended, Mr A said that the GP failed to perform a glucose finger prick and urine test despite his brother being unwell and complaining of frequent urination and increased thirst. Mr A wanted reassurance that lessons had been learnt from what had happened to his brother.

As part of the Ombudsman's investigation, the Practice provided evidence that the GP concerned had acknowledged clinical shortcomings. Additionally, as a result of this case she had engaged in significant reflection on how she could improve her clinical practice as well as taking practical measures such as improving her understanding of type 2 diabetes as well as her record keeping.

The Ombudsman was satisfied from the evidence provided that the GP and the Practice had taken adequate steps to prevent a recurrence of the events in Mr B's case. The Ombudsman requested that the Practice's Senior Partner write to Mr A to apologise for the shortcomings in care provided to Mr B and on the basis of the above settled the complaint.

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

[Case Number: 201802760 - Report issued in October](#)

Mr A complained about the care and treatment he received from the Health Board after two prostate procedures, following which he developed incontinence and had to be fitted with a permanent catheter in 2010. He said it had failed to fully explain the implications of catheterisation to him or why no better solution was available. He also said that since then the Health Board has provided fragmented care with no consistency and failed to plan his care appropriately.

Although the Ombudsman declined to investigate Mr A's complaint, he recognised the Health Board's complaint response provided an explanation of his care, and an apology for the limited success treatment had had in controlling symptoms. However, it appeared not all Mr A's concerns had been addressed adequately. Because of this, he contacted the Health Board and it agreed to do the following within **one month** of the date of this decision.

- a) To provide Mr A with a written explanation about the reason for a delay in providing him with a complaint response.
- b) To arrange to meet with Mr A to discuss his concerns about his care and why his treatment had limited success.

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

[Case Number: 201802885 - Report issued in October](#)

Mr X complained about the care and treatment provided to his late mother when she was admitted into hospital with a bad chest.

Mr X complained to the Health Board in March 2018 however, to date, he had not received a final response.

The Health Board agreed with the Ombudsman to respond to Mr X by 30 November 2018.

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

[Case Number: 201802971 - Report issued in October](#)

Miss X complained that the Health Board failed to follow a doctor's plan which she said led to her having sepsis.

The Ombudsman found that the Health Board's own comprehensive investigation and complaint response had identified failings in staff following the doctor's plan by not taking Miss X's temperature for four hours, which would have triggered further intervention. The Health Board had apologised, but it had not outlined any actions which had been implemented to address the failure.

The Health Board therefore agreed to complete the following action by 19 November 2018:

- a) Feedback to relevant Ward staff the importance of monitoring a patient's temperature when treating resumed sepsis and to write to Miss X to confirm when this had been completed.

Welsh Ambulance Services NHS Trust - Ambulance Services

Case Number: 201803823 - Report issued in November

Ms A's complaint related to the provision of patient transport. She believed that the Trust was discriminating against her by denying her access to services because she did not wish to disclose details of her disability. She also complained that the Trust had failed to fully address her complaint.

Having fully considered the matter, the Ombudsman concluded that the Trust was following its policy by carrying out a Patient Needs Analysis (PNA) every time a request for transport was made. He also concluded that the events complained about had been fully investigated and responded to. However, the Ombudsman contacted the Trust as he was concerned that its process was causing considerable distress to Ms A. He asked if it would agree that Ms A would not be required to go through the checking process every time a transport request was made.

The Trust agreed that, once Ms A had submitted/provided evidence from a clinician in relation to her illness/needs, it would mark its system to record that she would not be asked the PNA questions on every call. The Ombudsman believed that this action was reasonable and would settle the complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201803984 - Report issued in November

Ms A complained about the lack of dignity and manner of staff towards her when she had suffered a miscarriage within the reception area of the A&E Department at Bangor Hospital. She complained about the miscommunication which had occurred following her miscarriage and information provided about the final arrangements.

The Ombudsman contacted the Health Board. Although it had accepted and apologised that the situation had not been handled in the most sensitive way, he believed that further redress for the miscommunication was appropriate. The Health Board agreed to provide Ms A with a payment of £250 in recognition of the additional distress caused due to the miscommunication that had occurred, to fund a suitable memorial for her baby.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201803432 - Report issued in November

Ms T complained that Cardiff and Vale University Health Board had failed to provide adequate care and treatment to her late father whilst he was a patient at Llandough Hospital in June 2017. She also complained that the arrangements for his discharge were poor. She was also unhappy with the Health Board's complaint response and the fact that two meetings with the Health Board had been cancelled.

The Ombudsman considered that there was a need for the Health Board to provide a more detailed response to her complaint. He contacted the Health Board and it agreed to:

- a) Write a letter to the complainant providing a more detailed response to your complaint
 - b) Offer her a further meeting with relevant staff to discuss matters arising from your complaint.
- It has agreed to complete this within 10 working days of the date of this letter.

The Ombudsman believes that this is a reasonable resolution to this complaint.

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

[Case Number: 201804390 - Report issued in November](#)

Mr P complained that the Board had missed opportunities to diagnose and treat his late mother for cancer before she sadly passed away in November 2017. He was unhappy with the Board's response letter at stage 2 of its complaints procedure and felt that there were outstanding matters that still needed answers.

The Board offered to meet with him and his family in July 2018, but, he had declined as he was awaiting his late mother's medical records. Having received the medical notes he discovered other matters that he wished to raise with the Board.

The Ombudsman considered his complaint and contacted the Board, which has agreed to

- a) Contact him and offer him a date for a local resolution meeting
- b) Consider the additional matters he wishes to discuss (those not previously dealt with in the Board's response) for inclusion in the meeting.

The board has already contacted Mr P and offered a date in November. I have suggested that he lists the outstanding matters in his response to the Board regarding the suitability of the meeting date offered.

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

[Case Number: 201803676 - Report issued in November](#)

Mrs B complained that the Health Board had failed to undertake 'Patient Story' work with her as agreed in a meeting to discuss the treatment it had provided to her late husband, Dr B. Mrs B also complained that the Health Board had not responded to further concerns she made to it in March 2018.

The Health Board agreed to complete the following actions in settlement of Mrs B's complaint by 3 January 2019:

- a) Apologise to Mrs B for failing to undertake actions agreed in the meeting
- b) Either agree to now complete the Patient Story work, or provide reason/s to Mrs B for the decision not to do so
- c) Provide a response to Mrs B's outstanding concerns
- d) Make a payment of £250 to Mrs B for the time and trouble in making her complaint to the Ombudsman.

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

[Case Number: 201804454 - Report issued in November](#)

Miss X complained about the care and treatment received in hospital while in labour. She was taken for an Emergency Caesarean Section and said that her baby was delivered distressed and deprived of oxygen.

Miss X also also complained that she had not received a response from the Health Board to a complaint she submitted in May 2018.

The Ombudsman could not consider the substantive complaint until the Health Board had issued its response. However, he was concerned about the delay and so he contacted the Health Board. It told the Ombudsman that the response had been drafted and was in the final stage of approval. It therefore agreed to issue the response no later than 30 November 2018.

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

[Case Number: 201803605 - Report issued in November](#)

Miss X complained about events surrounding the birth of her daughter in 2018. Miss X said that she had to have an emergency caesarean section due to her baby's position and large size. She believed the latter should have been identified sooner by midwives. In addition, Miss X felt that she should have been tested for diabetes due to her symptoms whilst she was pregnant. Miss X raised concerns in relation to

her re-admission to hospital a few days after her initial discharge. These included a lengthy delay in the administration of antibiotics and a lack of observations carried out when Miss X was on the ward. Lastly, Miss X complained about the delay that she had experienced whilst waiting for the results of a later ultrasound scan with her new-born baby.

The Ombudsman concluded that, given the actions already taken by the Health Board, it was unlikely that an investigation by this office would achieve anything more for Miss X regarding part of her complaint. Therefore, he declined to investigate the complaint relating to delays in antibiotics and a lack of observations. However, the Ombudsman noted that other aspects of Miss X's complaint had not been fully addressed in the formal complaint response. Because of this, the Ombudsman contacted the Health Board and it agreed to carry out the following, within four weeks, in settlement of these aspects of the complaint:

- a) Provide Miss X with a further written response that fully addresses all of the identified outstanding concerns

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

[Case Number: 201803855 - Report issued in November](#)

Mr X complained about the care that his late mother, Mrs Y, received during her admissions to Morriston Hospital in late 2016 and early 2017. Mr X raised many concerns, including the management of Mrs Y's diabetes and pain, the standard of nursing care, as well as a lack of communication both with the family and between staff.

The Ombudsman concluded that, given the actions already taken by the Health Board, it was unlikely that an investigation by this office would achieve anything more for Mr X regarding many aspects of his complaint. Therefore, he declined to investigate the complaints relating to issues such as nursing care, communication and a lack of dignified care. In relation to other elements of Mr X's complaint, the Ombudsman contacted the Health Board and it agreed to carry out the following, within eight weeks, in settlement of these:

- a) Obtain an independent clinical view on the management of Mrs Y's diabetes during her periods of admission.
- b) Obtain an independent clinical view on Mrs Y's pain management during her admissions.
- c) Provide an explanation about why Mrs Y was kept nil-by-mouth between 21 to 24 February 2017 and whether this was appropriate.

[Powys Teaching Health Board - Continuing care](#)

[Case Number: 201804359 - Report issued in November](#)

Mrs X complained that the Health Board had failed to provide her client, Mrs Y, with the 28 hours per week of care assistance she had been assessed as needing. Mrs Y was left without this provision from August 2017 onwards. As a result of this lack of provision, Mrs Y needed assistance from her son and daughter, the burden of which, she said, had a significant impact upon their health and wellbeing. The Health Board had accepted that the provision had not been made and explained that this was due to the lack of carers able to provide for Mrs Y's specific care needs.

The Health Board agreed to review the lack of care provision since August 2017 in order to establish what harm may have resulted to Mrs Y and to determine what redress was appropriate. The Ombudsman considered this to represent a reasonable settlement.

[Powys Teaching Health Board - Continuing care](#)

[Case Number: 201803008 - Report issued in November](#)

Mrs A complained about the way in which Powys Teaching Health Board ("the Health Board") interpreted documentation submitted in support of a claim for retrospective continuing health care. Mrs A felt that it

had not been viewed in a subjective manner. Mrs A also complained about the length of time taken by the Health Board to advise her of the stages of progression and the eligibility decision.

As Mrs A had not raised any specific concerns based on the procedure followed by the Health Board in reaching its decision the Ombudsman determined that there were no grounds for investigation of this part of the complaint. However, the Ombudsman having seen information from the Health Board was satisfied that the Health Board had delayed sending Mrs A the eligibility decision by four months.

In consequence the Health Board agreed to provide Mrs A with an unreserved apology for any distress caused to her by this delay.

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

[Case Number: 201800289 - Report issued in November](#)

Mrs T complained about the overall care and treatment given to her husband, Mr T, following his admission to University Hospital of Wales in late April 2016 up to his death on 9 June. In particular, Mrs T was unhappy at its failed attempts to insert a central venous catheter.

Following the decision by the Ombudsman to investigate Mrs T's complaint, Mr T's medical records were requested from the Health Board. Unfortunately, they could not be found and the Ombudsman decided

that the loss of Mr T's medical records effectively prevented Mrs T from having her complaint about the treatment her husband experienced being investigated. The Ombudsman considered that this amounted to a significant injustice.

To settle the complaint, the Health Board agreed to apologise to Mrs T and make a redress payment of £2,500. The Health Board also agreed to continue searching for the medical records, to update the Ombudsman every two months on its progress, and put in place measures to prevent such losses in the future.

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

[Case Number: 201802653 - Report issued in November](#)

Mr A complained that over a period of four years, his brother-in-law ("Mr B") saw a succession of specialists without there being an agreed diagnosis and that the clinicians remained focused on their own specialism. He said that the clinicians' failure to effectively communicate with each other meant that there was a failure to look at his brother-in-law's clinical picture as a whole, and consequently only pain management was offered to him.

Following the Ombudsman's decision to investigate Mr A's complaint the Health Board offered to settle the complaint. The Ombudsman considered this to be reasonable and agreed to settle the complaint on the following terms which included the Health Board:

- a) carrying out an independent review of Mr B's care, by appointing a Consultant Neurologist and a Consultant Orthopaedic Surgeon
- b) on completion of the review, the Health Board reviewing this case to consider what lessons can be learnt to prevent a recurrence and taking steps to implement, within a timely manner, any measures/actions identified as required.

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

[Case Number: 201804004 - Report issued in November](#)

Mr Y complained to the Ombudsman about a number of issues relating to a delay he experienced in receiving surgery to remove his gall bladder; the manner in which the Health Board performed the procedure; and the way in which it followed up the procedure post operatively. He also complained

specifically that during a procedure to insert a stent following the surgery a doctor caused an injury to his back and also that the operating surgeon allowed a piece of gall bladder to fall inside his body which Mr Y considered was the source of his ongoing pain.

The Ombudsman decided that the Health Board had provided reasonable explanations, and where indicated, appropriate apologies for any shortcomings identified. The Health Board also agreed to take action to reduce the risk of future errors recurring. The Ombudsman considered that an investigation of these issues was disproportionate. The Ombudsman did recognise that the Health Board had failed to provide an appropriate response to Mr Y in relation to the back injury he complained about and failed to explain the circumstances that led to a piece of gall bladder falling inside his body during surgery. The Health Board agreed to look at these issues again and respond to Mr Y within six weeks. The Ombudsman considered this was reasonable and concluded the matter on this basis.

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

[Case Number: 201804435 - Report issued in December](#)

Mr B complained that he remained unhappy following receiving a response from the Health Board to his original complaint in May. However, an Advocate wrote a response on behalf of Mr B to the Health Board (in June) which raised additional matters (surrounding the PIP process and the Health Board's staff input to that in December 2017).

The Ombudsman contacted the Health Board who acknowledged the complaint and explained that it would investigate, respond and arrange a meeting afterwards.

The Ombudsman considered that this action was reasonable, and the Health Board agreed to undertake the following in settlement of the complaint:

- a) Provide a formal response to Mr B's advocate letter **within 4 weeks**
- b) Apologise to Mr B for the delay
- c) Agree a meeting date within 1 month of the response.

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

[Case Number: 201805266 - Report issued in December](#)

Mr S complained about the care and treatment that his mother received from Ysbyty Glan Clwyd and Llandudno General Hospital between 8 May to 13 June 2018. Mr S said that during this time, the Health Board failed to engage with the family regarding his mother's care, and they were not informed about a palliative care note.

Mr S said that the Clinical Lead and Orthopaedic Consultant was obstructive and unhelpful.

The Ombudsman noted that the Health Board had provided a written response to Mr S's initial complaint in November 2018. However, Mr S was of the view that the Health Board's response contained factual errors and it failed to address his complaint. He subsequently wrote a follow up letter on 19 November 2018. The Ombudsman noted that Mr S had not received a response to that letter, and the Health Board did not have timescales with regards to responding to follow up letters. The Ombudsman concluded that it would be helpful for Mr S to receive a response.

The Health Board agreed to provide a written response to Mr S's letter of 19 November 2018 by 27 February 2019 in resolution of his complaint.

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

[Case Number: 201804752 - Report issued in December](#)

Mrs P complained that the Health Board had not provided her with an update after a local resolution meeting she had attended with it on 27 June 2017. The meeting resulted from a complaint she had made to the Health Board regarding the standard of treatment and care provided to her late mother at two

hospitals managed by the Health Board.

The Ombudsman contacted the Health Board and it agreed to:

a) Write a letter to Mrs P apologising for any confusion following the meeting with it on 27 June 2017.
and

b) Provide an up to date copy of the action plan resulting from the meeting.

This should be completed within 20 working days of the date of my decision letter.

The Ombudsman considers that this a reasonable resolution to the complaint made by Mrs P.

[A GP Practice in the Abertawe Bro Morgannwg University Health Board area - Patient list issues](#) [Case Number: 201804568 - Report issued in December](#)

Mr and Mrs X complained about Mrs X's removal from the Practice's patient list, and the Practice's failure to provide a response to their complaint about this. The Practice told the Ombudsman that, whilst it had responded to a complaint from Mr X, it had not responded to the separate complaint made by Mrs X.

The Practice operated a "whole families only" registration policy and when it decided to remove Mr X from its Practice list it also removed Mrs X. However, the Practice failed to provide reasons to Mrs X for her removal as required under regulations. Additionally, the Ombudsman did not consider that the Practice's registration policy was sufficiently clear in explaining to its patients that the entire household would be removed from the Practice's list where a decision was made to remove one of the householders.

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

To be completed **by 22 January 2019**:

- a) Apologise to Mrs X for failing to respond to her complaint, and respond to her complaint providing reasons for her removal from the Practice list
- b) Pay Mrs X £125 in recognition of the failure to respond to her complaint; and pay her a further £125 in recognition of the failure to provide reasons for her removal from the Practice list, and for the distress caused by this.

To be completed **by 22 March 2019**:

- a) To review its policy to provide clarity on off-listing entire households
- b) To review its procedures to ensure that all decisions taken to off-list a patient are fully recorded in accordance with the Regulations and other relevant guidance
- c) Practice staff to undergo training on the revised policy, procedures, and their implementation.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201804652 - Report issued in December](#)

Mrs X complained that she experienced delays and a cancellation whilst awaiting knee surgery; that the Health Board failed to investigate and respond to her concerns about surgery cancellation; and that it failed to appropriately manage her post-surgical wound.

Whilst the Health Board had apologised for its complaint handling failure, and had provided a reasonable response to Mrs X's concerns about the delays and surgery cancellation she had experienced, it had not offered an apology to Mrs X.

Furthermore, the Health Board had been unable to respond to Mrs X's wound management concerns as it had lost her records for the relevant period. As the Health Board subsequently located Mrs X's records, it agreed to complete the following by 31 January 2019 in settlement of the complaint:

- a) Apologise for the cancellation of Mrs X's surgery and the delays she experienced, and for failing to provide a response to Mrs X's complaint about wound management

- b) Provide a 'Putting Things Right' response to Mrs X's wound management concerns
- c) Make a payment of £250 to Mrs X for failing to respond to her wound management complaint, and for the time and trouble in making her complaint to the Ombudsman.

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

[Case Number: 201805569 - Report issued in December](#)

Mr X complained that the Health Board's delay in performing a heart bypass operation on his brother, resulted in his premature death. In 2016, the Health Board had decided that no further treatment was appropriate at that time. In 2017 the Health Board performed heart bypass surgery, but unfortunately Mr X's brother died shortly after.

The Ombudsman felt that further information and explanations could have been provided to Mr X. The Health Board therefore agreed with the Ombudsman to complete the following in settlement of Mr X's complaint:

By 9 January 2019:

- a) Provide Mr X with a further written response to explain the reasons behind its decision that nothing further could have been achieved from a cardiac perspective in 2016.
- b) Explain to Mr X the options that were considered and why they were not appropriate, such as performing an angiogram.

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

[Case Number: 201805647 - Report issued in December](#)

Mrs X complained that an out of hours Doctor acted inappropriately by lifting her top and unbuttoning her trousers without seeking her permission. She felt humiliated and violated. Mrs X also said that the experience caused her to lose her voice and she needed to attend speech and language therapy.

The Ombudsman concluded that the Health Board had taken appropriate action to address the concerns, and that the Doctor had reflected on the consultation and had offered a personal apology to Mrs X. There was no clinical evidence to link her voice loss to the consultation. However, the Ombudsman noted there was a considerable delay in issuing its response letter. The Health Board agreed with the Ombudsman to do the following in settlement of Mrs X's complaint:

By 10 January 2019:

- a) Provide Mrs X with an apology, acknowledging the delay.

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

[Case Number: 201804897- Report issued in December](#)

Mrs D complained that the Health Board had failed to respond to her complaint about the treatment provided to her deceased mother, which she made to it in January 2018.

The Ombudsman found that the Health Board had failed to provide meaningful updates to Mrs D during the course of its investigation. The Health Board agreed to complete the following in settlement of Mrs D's complaint by 15 January 2019:

- a) Apologise to Mrs D for the delay in responding to her complaint, and for the failure to provide meaningful updates
- b) Issue its final PTR response
- c) Pay Mrs D £250 for her time and trouble in making her complaint to the Ombudsman

[Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#)

[Case Number: 201804423](#)– Report issued in December

Mrs X complained about the care her late daughter, Y, received from the Health Board's Community Mental Health Team in the months prior to her death by suicide in July 2017. The Health Board had carried out an incident review of Y's care, which Mrs X participated in, and subsequently issued an investigation report.

Mrs X formally complained to the Health Board in March 2018 about her daughters care and the contents of the investigation report. Following this, she met with relevant staff in May 2018 and received a response which provided an amended version of the incident investigation report. However, the response did not address in full the issues Mrs X had raised in her complaint.

The Health Board also failed to send Mrs X a CD audio recording of the meeting which they had promised. The Ombudsman concluded that this did not provide an adequate response to Mrs X's complaint

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

- a) send Mrs X a CD recording of the meeting; and
- b) provide a full response to her complaint by 31 January 2019.

[Hywel Dda University Health Board - Patient list issues](#)

[Case Number: 201803503](#) - Report issued in December

Mr A complained that despite his son being on the waiting list for orthodontic treatment for a number of years his son was no further forward in terms of being treated. Mr A noted that his son had now developed problems with his teeth. Mr A was also dissatisfied that despite the Health Board indicating in a previous complaint response that his son would have treatment in early 2018 this had not materialised.

The Health Board provided evidence to show that it was taking steps to improve communication, including with its contracted dental provider. It also highlighted measures it had introduced to improve orthodontal waiting times. The settlement agreed with the Ombudsman included Mr A's son undergoing a specialist orthodontal review to determine his clinical needs and priority. In addition, the Health Board said it would provide a written apology for misinformation it had provided and a payment of £250 for the time and trouble caused to Mr A as a result of having to bring a complaint to the Ombudsman.

Agriculture and Fisheries

Early Resolution or Voluntary Settlement

Rural Payments Wales – Welsh Government - Payment schemes

Case Number: 201802630 - Report issued in October

Ms X (a solicitor) complained on behalf of her clients who had applied, in 2015, to Rural Payments Wales (“RPW”) for payments under the Common Agricultural Policy Basic Payment Scheme (“CAP payments”). Ms X had submitted both a complaint to RPW and also lodged an appeal against the decision of non entitlement to CAP payments. In January 2018, Ms X lodged the supporting evidence for the appeal that had been filed some months earlier. She complained that no date for the appeal had been fixed, that RPW had failed to consider evidence submitted as part of the complaint and complained about the delay in RPW’s handling of her complaint. A final complaint response was sent in May 2018.

The Ombudsman considered that aspects of Ms X’s complaints were out of time and that an appeal was a remedy available to her (both restrictions under the Act governing the Ombudsman’s work). Whilst there had been a delay in responding to Ms X’s complaint, this had partly been as a result of her complaint letter conflating with her grounds of appeal (still pending). Further, RPW had already apologised for the delay in responding to the complaint. However, the Ombudsman felt that there had been undue delay since the evidence was lodged with no hearing fixed, and that the appeal procedure documents lacked some clarity.

RPW therefore agreed to implement the following recommendations:

- a) To apologise (within one month) for the delay in setting the appeal hearing;
- b) To make arrangements, within one month, to fix a date for the hearing as soon as practicable and notify Ms X of it;
- c) To review the appeals process document on Stage 2 appeals and provide clarity on the submission of evidence, such review to be completed within three months.

Benefits Administration

Early Resolution or Voluntary Settlement

Isle of Anglesey County Council - Council Tax Benefit

Case Number: 201802865 - Report issued in October

On behalf of her client, Mrs B, an advocate (Ms A) said that Isle of Anglesey County Council ("the Council") had investigated her earlier complaint about Mrs B's Council Tax liability, and it had accepted failings in the administration of her account. Those failings resulted in errors for a number of years, and a demand for significant sums. The Council had apologised for those failures and wrote off the sums. However, some days later, Mrs B had received a further Notice of Liability Order from the Council (for Court costs associated with the previous "arrears"), which had greatly distressed her further.

The Ombudsman found that the Council had acknowledged its previous errors but there had clearly been a further failing in communication between officers resulting in the Notice being sent to Mrs B. It should not have been, and the Council apologised for this. The Ombudsman, however, made the following recommendations to resolve the issue, all of which the Council agreed to implement (within one month):

- a) To offer £250 to Mrs B for the further distress caused and her time in having to pursue the complaint with the Ombudsman.
- b) To consider an application to the Magistrates Court (if possible) to set aside the costs order made against her (undertaken at its own cost) or clearly note the record that this sum was written off.
- c) Provide an action plan to the Ombudsman to demonstrate how the recurrence of these failings could be avoided.

Complaints Handling

Upheld

[Hywel Dda University Health Board - Health](#)
[Case Number: 201704112 - Report issued in October](#)

Mrs Y complained about the care and treatment she received following suspected deep vein thrombosis ("DVT", a blood clot that develops within a deep vein in the body, usually in the leg) after a road traffic collision in March 2016. Mrs Y also complained that there was a failure to appropriately treat the symptoms of pain in her shoulders, neck and lower back. In addition, Mrs Y complained that Hywel Dda University Health Board's ("the Health Board") handling of her complaint was inadequate.

The Ombudsman found that there was an unacceptable delay in providing Mrs Y with a doppler scan and that, following a rectal bleed on 25 March, she should not have been administered with a further dose of heparin (a blood thinning medication which prevents the blood from clotting) and a doppler scan (a specialised scan used to find out how fast the blood is flowing through a blood vessel which helps identify a blood clot) should have been undertaken prior to her discharge in the early hours of 26 March.

The Ombudsman considered the lack of undertaking a doppler scan on 25 March to be a service failure and the fact that Mrs Y was not treated expeditiously on that day and suffered additional distress due to a further bleed which necessitated a blood transfusion, to be an injustice to Mrs Y. This complaint was upheld.

The Ombudsman was satisfied that the examination of the pain in Mrs Y's shoulders, neck and lower back was thorough and reasonable during an examination on 22 March. Whilst he recognised Mrs Y's concern that there was no record of her complaints of neck and shoulder pains and difficulty with neck movement, on balance, having considered all of the evidence available to him, he did not uphold this complaint.

[A GP Surgery in the area of Abertawe Bro Morgannwg University Health Board – Health](#)
[Case Number: 201702375 - Report issued in October](#)

Mr X complained that the care and treatment provided to his wife, Mrs X, between November 2016 and January 2017 by GPs at the Surgery was inadequate. Mr X said that Mrs X attended seven appointments throughout this time with concerns that her physical symptoms could be attributed to re-occurring cancer.

Mr X said that, due to her symptoms, the GPs should have been referred Mrs X to the Health Board's Oncology Service for further treatment that may have prolonged her life.

The Ombudsman found that, at four appointments, the GPs did not act reasonably as they failed to discuss Mrs X's ongoing symptoms with the Oncology Service. However, the Ombudsman only partially upheld the complaint as he found that, whilst a referral to the Oncology Service would have resulted in the provision of additional pain-relieving treatment and medication, due to Mrs X's advanced illness, further active cancer treatment would have been unlikely to have had any benefit.

The Ombudsman recommended that the Surgery apologises to Mr X and provides him with a redress payment of £100 to reflect the four missed opportunities that the GPs could have contacted the Oncology Service so that pain relieving treatment and medication could have been provided to Mrs X. The Surgery agreed to implement the recommendations.

Betsi Cadwaladr University Health Board - Health

Case Number: 201707734- Report issued in December

In 2013, Mrs X was diagnosed with dementia and intermittent confusion. On 17 July 2017, Mrs X became suddenly confused, staring, not knowing where she was, crying and not talking. She was taken to Llandudno General Hospital ("the First Hospital"), her electrocardiogram result (ECG) was within normal limits. Mrs X was transferred to Ysbyty Glan Clwyd ("the Second Hospital"), her observations were within normal ranges and she was discharged. The next day Mrs X reattended the Second Hospital and a CT scan showed that she had suffered a small stroke. Mr X complained about the treatment Mrs X received on 17 July.

The Ombudsman found that although Mrs X had not presented with obvious symptoms of a stroke,

the sudden onset of speech disturbance and unsteadiness of gait were in keeping with a stroke. Mrs X's differential diagnosis was an infection or stroke, infection was excluded and she should have had a CT scan to confirm or refute the diagnosis of a stroke. The Ombudsman upheld this complaint. The Health Board agreed to implement his recommendations and apologise to Mr and Mrs X for the failing, make a redress payment of £500 and reviews whether there is a training need to help staff identify patients suffering less common symptoms of a stroke.

Early Resolution or Voluntary Settlement

Neath Port Talbot County Borough Council - Planning and Building Control

Case Number: 201801973 - Report issued in October

Mr D complained regarding numerous issues regarding the Council's service and operational actions. Included in his complaint were issues regarding the oversight of an investigation by Swansea City Council over the possible misadministration of medicine to his mother whilst in a care home in that area. There was also a failure to respond to his written query regarding a traffic order at Seaway Parade, Port Talbot and the apparent overcharging of his mother's care payments,

The Ombudsman discovered that the above mentioned issues required further responses from the Council. It contacted the Council and it agreed to

- a) Write a letter to him confirming that it has contacted Swansea City Council regarding the investigation into his mother's medication issues and that it will advise him of the outcome of it as soon as it is known
- b) Write a letter to him replying to his query regarding the traffic order at Seaway Parade.
- c) Provide him with an up to date position statement regarding his mother's care payments.

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

The Ombudsman believes that the actions agreed by the Council will resolve the issues highlighted in the complaint.

Betsi Cadwaladr University Health Board - Health

Case Number: 201803507 - Report issued in October

Mr J complained that he had not been cared for or treated at all whilst at the Medical Assessment Unit Ward at [redacted] Hospital between 0930 and 2115 hrs on 26 July 2017. He contested that his medical records showed that he had received fluids at regular intervals during the period in question. Mr J also complained that he had received a letter from the Board on 29 May 2018 stating that it was going to review his case. He had not received any communication since then.

The Ombudsman considered whether his complaint was out of time as it was more than twelve months since the incident. He decided to use his discretion in allowing part of his complaint to be assessed. He confirmed that there had been no communication between the Board and the complainant since May

2018. He contacted the Board and it agreed to

- a) Write to Mr J and advise him of the current situation with the review of his case and provide him with an estimated timeline of completion.

The Ombudsman is satisfied that this will provide a resolution to the issues considered in the complaint.

[Hywel Dda University Health Board – Health](#) [Case Number: 201802890 - Report issued in October](#)

Ms X complained that the Health Board failed to efficiently handle a complaint raised about the delay in reviewing her medication and previously providing incorrect information.

The Health Board agreed with the Ombudsman to undertake the following in settlement of this complaint:-

- a) Address and issue a full response to Ms X, by **14 December 2018**.
- b) Issue a formal apology together with a redress payment of £100 to Ms X for her time and trouble in pursuing these matters with the Health Board, **by 31 October 2018**.

[Betsi Cadwaladr University Health - Health](#) [Case Number: 201803100 - Report issued in October](#)

Mr X's representative complained that the Health Board failed to respond to a complaint within six months as it had indicated it would in January 2018. At the time of complaining to the Ombudsman in August, Mr X complained that the Health Board had not concluded its investigations into the concerns raised.

The Health Board agreed with the Ombudsman that it would undertake the following in settlement of the complaint: -

- a) Provide an update letter to Mr X's representative (which was sent by email on 28 September 2018.)
- b) Issue a full Putting Things Right response **no later than 31 October 2018**.

[Abertawe Bro Morgannwg University Health - Health](#) [Case Number: 201803154 - Report issued in October](#)

Mr X complained that the Health Board failed to efficiently control the chemotherapy programme delivered to his wife in early 2017. There was a lack of communication between the staff which all contributed to a misdiagnosis and led to her death. He also complained that the Health Board had failed to respond to his additional questions in a letter he had sent in March 2018.

Having considered the evidence before him, the Ombudsman declined to investigate the substantive issue. It was out of time and as there has been an independent investigation through the Coroner's office, finding that treatment was appropriate, any consideration by the Ombudsman would not achieve a different outcome. However the Ombudsman felt that the Health Board should have replied to Mr X's subsequent letter and that this was a communication failure. The Health Board recognised that it failed to respond and consequently offered to pay Mr X £250 in recognition of this failure. The Health Board also agreed with the Ombudsman to undertake the following:

- a) Agree a meeting date with Mr X by 31 October 2018;
- b) Issue a response within two weeks following the meeting.

[Abertawe Bro Morgannwg University Health Board - Health](#) [Case Number: 201803097 - Report issued in October](#)

Mrs A complained that the Health Board had failed to respond to her complaint about the treatment provided to her late father, Mr B, which she made to it on 31 May 2018.

Although the Health Board had provided updates to Mrs A, it agreed to complete the following in settlement of Mrs A's complaint:

By 2 November 2018:

a) Apologise to Mrs A for the delay in responding to her complaint

By 16 November 2018:

a) Issue its final 'Putting Things Right' response.

[Abertawe Bro Morgannwg University Health Board – Health](#)

[Case Number: 201803448 - Report issued in October](#)

Mr A complained that the Health Board had failed to issue notes of a meeting, held in December 2017, relating to the treatment it provided to his late wife, Mrs A. Mr A attended the meeting with his mother-in-law, who had initially raised the complaint with the Health Board.

The Health Board, in settlement of the complaint, agreed to complete the following actions by 3 December 2018:

a) Issue the meeting notes to Mr A and any other person awaiting them

b) Apologise for the significant delay in issuing the notes to Mr A and any other person awaiting them

c) Pay £250 to Mr A in recognition of the significant delay and for the time and trouble in making his complaint to the Ombudsman.

[Hywel Dda University Health Board – Health](#)

[Case Number: 201802599 - Report issued in October](#)

Mrs X complained that the Health Board had failed to respond to her complaint, made to it in January 2018, about its involvement in her daughter's care. The Health Board issued its response shortly after Mrs X's complaint to the Ombudsman. The Health Board's response failed to apologise for its complaint handling delays.

The Health Board, in settlement of the complaint, agreed to write to Mrs X by 5 November 2018 to apologise for the delay.

[Hywel Dda University Health Board – Health](#)

[Case Number: 201803598 - Report issued in October](#)

Miss C complained that the Health Board had failed to adequately respond to her complaint about the treatment it had provided to her daughter.

The Health Board issued its complaint response to Miss C shortly after her complaint was made to the Ombudsman and apologised for its complaint handling delays.

Further to the Ombudsman's enquiries, the Health Board agreed to complete the following in settlement of Miss C's complaint by 27 November 2018:

a) Pay Miss C £125 for her time and trouble in making her complaint to the Ombudsman following the delays she experienced.

[Flintshire County Council - Adult Social Services](#)

[Case Number: 201803237 - Report issued in October](#)

Ms F, who has Autistic Spectrum Disorder, complained about the measures taken by Flintshire County Council (the Council) to respond to her requests for an assessment of her and her two children's needs by the Council's Social Services Department, and her request for an assessment of her eldest child's Special Educational Needs. Ms F had complained to the Council about these matters but at the time she

complained to the Ombudsman, had not had a response under Stage 2 of the Social Services Complaints Procedure.

In settlement of the complaint, the Council agreed to:

- a) commit to an indicative deadline of the end of December 2018 for completion of the assessment process (providing that Ms F is able to engage with the Council as may be necessary) and to agree any resulting measures to meet Ms F and her children's needs;
- b) apologise to Ms F and to offer her a small payment of £150 to reflect the failure to deal with her Stage 2 complaint, and the time and trouble she has gone to in pursuing her concerns; and,
- c) address an issue relating to public guidance on the Council's website about Stage 2 of the Social Services Complaints Procedure (which appears to wrongly indicate that the Council has some discretion whether to allow a complaint to go to Stage 2).

Abertawe Bro Morgannwg University Health Board - Health

Case Number: 201801819 - Report issued in October

Miss A complained about delays by the Health Board since June 2015, in providing Botulinum Toxin ("Botox") treatment of her involuntary facial contractions. She also complained about the Health Board's handling of her complaint.

The Ombudsman found that it was not the Health Board's policy to provide Botox treatment for patients with Miss A's condition. However, clinicians had been providing Botox treatment to some new patients outside of agreed clinical criteria and without having obtained the Health Board's formal approval to do so. Miss A was overlooked for this treatment until she complained. Although the Ombudsman could not say that her treatment was delayed, her sense of injustice at being overlooked was understandable. The Ombudsman also found that the Health Board's complaint investigation was not robust and its second response was unreasonably delayed. The Health Board agreed to undertake the following actions to remedy the failings identified:

Provide an immediate response to Miss A's second letter of complaint

- a) Make a redress payment of £250 to Miss A in recognition of the poor handling of her concerns.
- b) Review the practice of providing Botox treatment in the context of its policy and take steps to seek formal approval if it wishes to continue.

Powys Teaching Health Board – Health

Case Number: 201803633 – Report issued in November

Ms A complained that the Health Board acted unreasonably by breaching her privacy, denying her appropriate care and treatment, and discriminating against her. Ms A also complained that her complaint had not been handled correctly by the Health Board.

Although the Ombudsman declined to investigate Ms A's complaint, he was concerned that there had been a delay in fully responding to her complaint by the Health Board.

Because of this, he contacted the Health Board who agreed to provide Ms A with an apology for failing to advise her of a delay in responding to her complaint.

Betsi Cadwaladr University Health Board – Health

Case Number: 201803976 – Report issued in November

Mr J complained that the Board was unable to account for a suspected dislocation to his late grandmother's right shoulder whilst she was under its care in April 2017.

He also complained of failures in care and treatment for her during this period. He also complained that the Board's complaint handling was poor.

The Ombudsman decided that he was unable to achieve anything further for the complainant regarding the first parts of his complaint. He did however contact the Board regarding its poor complaint handling. It agreed to:

- a) Write a letter to Mr J apologising for the delays in complaint handling.
- b) Offer a payment of £250 in recognition of the time and trouble taken by.

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

The Ombudsman considers that this will resolve the part of Mr J's complaint about the Board's complaint handling.

[Aneurin Bevan University Health Board – Health](#) [Case Number: 201804521 - Report issued in November](#)

Ms H complained that the Health Board had failed to respond to her further concerns which she made to it in May 2018.

The Ombudsman found that the Health Board had failed to provide meaningful updates to Ms H during the course of its investigation and consideration of her further comments. The Health Board therefore agreed to complete the following actions by 9 January 2019 in settlement of Ms H's complaint:

- a) Issue its further response to Ms H's letter of 31 May 2018
- b) Apologise to Ms H for the delay and for failing to provide her with meaningful updates since then
- c) Offer a payment of £125 to Ms H for the time and trouble in making her complaint to the Ombudsman, and in recognition of its delay and failure to provide updates.

[Betsi Cadwaladr University Health Board – Health](#) [Case Number: 201804389 - Report issued in November](#)

Mr B complained that the Health Board had failed to respond to his complaint about the treatment it had provided to his deceased mother, and had failed to keep him informed about the progress of its investigation.

The Health Board issued its complaint response to Mr B shortly after his complaint was made to the Ombudsman, but after he had made initial enquiries with the Health Board.

Further to the Ombudsman's enquiries, the Health Board agreed to complete the following in settlement of Mr B's complaint by 24 December 2018:

- a) Apologise to Mr B for the delay in responding to his complaint, and for the failure to provide updates
- b) Pay Mr B £125 for his time and trouble in making his complaint to the Ombudsman

[Betsi Cadwaladr University Health – Health](#) [Case Number: 201804561 - Report issued in November](#)

Mr K complained that the Health Board had failed to respond to his complaint about the treatment it had provided to his wife, which he made to it in June 2018.

The Ombudsman found that the Health Board had failed to provide meaningful updates to Mr K. The Health Board agreed to complete the following in settlement of Mr K's complaint by 4 January 2019:

- a) Apologise to Mr K for the delay in responding to his complaint, and for the failure to provide meaningful updates
- b) Issue its final PTR response

[Betsi Cadwaladr University Health Board – Health](#) [Case Number: 201800859 - Report issued in November](#)

Mr X complained to the Ombudsman that the Health Board's complaint response letter did not address his concerns about the treatment he received from his Psychiatrist between May 2016 and August 2017. Mr X also complained that, as the Health Board were keeping his complaint correspondence separate to his medical records, the records were not an accurate reflection of his views on his clinical condition and

treatment. Additionally, Mr X complained that he had been told that he could only contact the Health Board by postal correspondence and that he was not offered appropriate clinical assistance after he was discharged from the Psychiatrist's care in August 2017.

In settlement of the complaint, the Health Board agreed to undertake the following actions, within one month of the date of the Ombudsman's decision letter:

- a) Provide Mr X with a written response addressing his concerns about the treatment he received from the Psychiatrist between May 2016 and August 2017
- b) Add a note to Mr X's medical records explaining that his views regarding his clinical condition and treatment from the Psychiatrist can be found in his complaint file
- c) Provide Mr X with written information explaining the scope of his restriction contacting the Health Board and any review processes that exist in relation to this.

[Powys County Council - Various Other](#)

[Case Numbers: 201804913 & 201804915 - Report issued in December](#)

Mr A and Mr Z complained about the Council's failure to investigate their complaints concerning public statements made by a senior officer of the Council, who, they said, had lied. They felt the statements made to be defamatory, distressing, and having had a consequential affect on their livelihood since they both stepped down as elected members of the Council. Mr A and Mr Z also complained about the Council's delay in investigating their complaints, which they first made in November 2017.

The Ombudsman declined to investigate the substantive matter as determining whether, or not, statements were defamatory was outside his jurisdiction. The allegation that the officer had lied was, the Ombudsman felt, a matter of staff conduct which was also not for him. Nevertheless, the Ombudsman was concerned about the poor complaint handling. Whilst the Council had acknowledged an earlier episode of delay, and apologised, it had further compounded the matter by failing to keep Mr A and Mr Z updated on its investigation, and failing to reply to a letter (dated 31 August 2018) from a solicitor they had instructed. The Ombudsman considered this to be unacceptable and made the following recommendations, which the Council agreed to implement (within one month unless stated differently):

- a) To offer an apology in writing to both Mr A and Mr Z for the continued delay in the handling/investigation of their complaints;
- b) To offer redress to both Mr A and Mr Z for the complaint handling delays and communication failings in the sum of £250 each;
- c) To offer an apology in writing to the solicitors acting for Mr A and Mr Z for the failure to reply to their letter;
- d) To provide a meaningful update to both Mr A and Mr Z (and their solicitors) with an action plan / timeline for concluding the investigation and responding in full to the complaint (update and action plan to be provided by 31 January 2019).

[Wrexham County Borough Council - Community Facilities. Recreation and Leisure](#)

[Case Number: 201805513 - Report issued in December](#)

Mr Y complained that the Council had failed to respond to his enquiries, made to it in July 2018, following a service request for broken fence posts to be removed from neighbouring land.

The Ombudsman found that the Council failed to provide a substantive response to Mr Y's enquiries following an initial complaint response provided in August 2018.

The Council therefore agreed to complete the following actions by 11 January 2019 in settlement of Mr Y's complaint:

- a) Apologise for failing to respond to Mr Y's enquiries
- b) Provide a complaint response at Stage 2 of the Council's complaints procedure
- c) Pay Mr Y £50 for the time and trouble in making his complaint to the Ombudsman.

Flintshire County Council - Housing

Case Number: 201804860 - Report issued in December

Ms X complained about the actions and behaviour of a Housing Officer in relation to a caravan located on her property. Ms X also complained that the Council failed to assist her and inform her of her rights and that it failed to appropriately deal with her complaints.

The Council acknowledged to the Ombudsman that a complaint was received in February 2018 but a response was never issued. It accepted that the correct process was not followed and said that this would be highlighted to its staff. The Council agreed with the Ombudsman to undertake the following in settlement of this complaint: -

- a) Immediately escalate Ms X's complaint to Step 2 of its complaints process.
- b) Complete its investigation within four weeks.
- c) Offer a redress payment of £50 for having to escalate the matter to the Ombudsman.

Caerphilly County Borough Council - Childrens Social Services

Case Number: 201805065 - Report issued in December

Mr X complained about the Council's refusal to progress his complaint about Children's Services to Stage 2 under its Social Services complaints procedure when requested by Mr X.

The Ombudsman contacted the Council because he was concerned that under the relevant regulations, it is obliged to progress complaints to Stage 2 once a request is made. The Council agreed to carry out the following in settlement of the complaint **by 22 January 2019**:

- a) Investigate Mr X's complaint under Stage 2 of the Complaints Procedure
- b) Remind relevant staff of the obligation to consider similar requests under Stage 2 of the process
- c) Make a payment of £50 to Mr X for the time and trouble in making a complaint to the Ombudsman.

Caerphilly County Borough- Adult Social Services

Case Number: 201805645 - Report issued in December

Mr F complained about the Council's refusal to progress his complaint about Adult Services to Stage 2 of its Social Services complaints procedure following his request to do so.

The Ombudsman contacted the Council who said that it had declined to progress the matter to Stage 2 as there were concurrent court proceedings under consideration, so it was not obliged to. However, the Ombudsman was concerned that, under the relevant regulations, the Council is obliged to inform the complainant in writing that, where the concurrent consideration has been discontinued or completed, the complainant can resubmit the complaint to the Council no later than 6 months after the concurrent matter has ended. It had not done so in Mr F's case. The Council agreed to carry out the following in settlement of the complaint by **23 January 2019**:

- a) Write a letter of apology to Mr F for omitting this from its letter
- b) Re-issue its decision letter to include this additional information.

Cardiff and Vale University Health Board – Health

Case Number: 201803192- Report issued in December

Mr A complained to the Ombudsman following the investigation carried out by Cardiff and Vale University Health Board ("the Health Board") into his complaint. Mr A complained about its written response to his complaint.

The Ombudsman decided that he would not investigate the complaint at this time, however, the Health Board was contacted and agreed to facilitate a meeting with Mr A to settle his complaint. The Ombudsman considered, consequently, that Mr A's complaint had been settled.

Education

Upheld

Cardiff Council - School Transport

Case Number: 201705888 - Report issued in November

Mrs G complained about Cardiff Council's ("the Council's") decision to withdraw school to home transport funding for her son, X, which she believed was contrary to the Council's duty under section 4 of the Learner Travel (Wales) Measure 2008. Mrs G also complained that there were procedural shortcomings in the Council's handling of the matter: specifically, that it failed to provide adequate reasons for its decision, did not carry out an assessment of X's needs, and failed to follow the correct appeal procedure.

The Ombudsman found that there were flaws in the Council's assessment of X's eligibility for home to school transport funding; specifically, that there was a lack of written documentation of the assessment, insufficient reasons were given for the decision and the Council failed to follow the appeal process set out in its policy. The Ombudsman upheld the complaints to that extent. However, he also concluded that X would not have been eligible for free transport in any event as the transport was being requested to a place other than X's home. The Ombudsman recommended that the Council should apologise to Mrs G for the failings identified and pay her financial redress of £250 to reflect the time and trouble she had been put to. He also recommended that the Council should remind relevant staff of the need to ensure a written record is made of assessments and that adequate reasons for decisions should be given to parents.

Early Resolution or Voluntary Settlement

Wrexham County Borough Council – other

Case Number: 201802930 - Report issued in October

Miss A complained that the Council failed to undertake the consultation process in relation to the closure of a primary school in line with statute and guidance.

Although the Ombudsman declined to investigate Miss A's complaint, he was concerned that the Council had refused to investigate Miss A's complaint under Stage 2 of its own Complaints Procedure. Because of this he contacted the Council who agreed to investigate Miss A's complaint in line with Stage 2 of its Complaints Procedure.

Cardiff Council - Special Educational Needs (SEN)

Case Number: 201804274 - Report issued in November

Ms A complained that in 2016, Cardiff Council ("the Council") failed to include one of her son's, B, diagnosed condition and to make the necessary provision in his statement of special educational needs ("SEN statement"). Ms A said at the annual review of B's SEN statement in 2017, the Council decided B's SEN statement was sufficient to meet his educational needs and decided not to amend his SEN statement. At the annual review of B's SEN statement in 2018, the Council had failed to inform Ms A whether B's SEN statement should be amended to meet his current educational needs.

The Ombudsman could not consider Ms A's complaint in 2016, as she had a right of appeal to the Special Educational Needs Tribunal (Wales) about B's SEN statement. However, the Council agreed with the Ombudsman to appoint an Investigator, independent of the Council, to consider Ms A's concerns. The Council also agreed to write to Ms A with its decision on B's current SEN statement, and apologise to her for its delay.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

[Bridgend County Borough Council - Refuse collection, recycling and waste disposal](#)

Case Number: 201803731 - Report issued in October

Mr X said he had raised several complaints with the Council regarding the poor collection of his refuse. He complained to the Ombudsman that the Council had failed to address his concerns and they were therefore unresolved.

The Ombudsman noted that the Council was the service provider in this instance, even though it had contracted out the waste collection work to a third party. It was also responsible for addressing the complaint. The Council agreed with the Ombudsman to undertake the following in settlement of this complaint: -

- a) Undertake a Stage 2 investigation (in line with its complaints procedure), with a reply from a Senior Council Officer to be issued **no later than 26 October 2018**.
- b) Issue a redress payment of £100 for the time and trouble in pursuing the complaint.

[Gwynedd Council - Pollution and pollution control measures](#)

Case Number: 201804291 - Report issued in December

Mr A complained that the Council had not taken action against his neighbour (Mr B) who was conducting excavation works upstream from his property. Consequently, Mr A's private water supply had become polluted. The Council undertook an inspection visit but said that the works carried out by Mr B posed no flood risk. Another division of the Council had in the meantime tested the water supply. It issued Mr A with a statutory notice, also billing him for the cost of testing, which Mr A was very unhappy about.

On considering the evidence, the Ombudsman noted that the Council had acted quickly in visiting Mr B. It had concluded that no flood risk was posed by the works he was carrying out. The Council also promptly tested Mr A's water supply, finding it to contain cloriforms (harmful bacteria). In pursuant of its statutory duty, the Council was bound to issue Mr A, as the "relevant person", with the notice. The law also entitled it to invoice Mr A for the cost of testing. The Ombudsman is precluded by law from questioning the professional judgement of officers in such matters, even though Mr A disagreed with their findings. However, the Ombudsman found that Mr A had submitted additional evidence since the original flood risk inspection, which was conducted during the dry summer months. He considered that this additional information, together with the rainfall associated with winter months, should have prompted the Council to re-assess the position given Mr A was still complaining and suffering the effects of the works. The Council therefore agreed to undertake the following in resolution of Mr A's ongoing concerns:

- a) To undertake a further inspection visit and investigation concerning flood risk, providing Mr A with its decision by 31 January 2019.

Finance and Taxation

Early Resolution and Voluntary Settlement

Denbighshire County Council - Finance and Taxation

Case Number: 201804662 - Report issued in December

Mr B complained that the Council had wrongly assessed the liability of the estate of the late Mr C (for which Mr B was an executor) to pay Council Tax for the period after Mr C's death until his home was sold. Mr B also complained that the Council had provided him with a number of Council Tax bills over that period, each asking for a different amount in payment.

Although the Ombudsman declined to investigate Mr B's complaint, he was concerned that the Council had not applied a relevant exemption to the Council Tax bill on the sale of the property, despite having been notified of the exemption several months earlier. This meant that the bill issued on the sale of the property was incorrect and led to the issuing of a further Council Tax bill.

Because of this the Ombudsman contacted the Council who agreed to apologise to Mr B and his fellow executors and beneficiaries for the delay in applying the correct exemption to the Council Tax bill, which led to an incorrect bill being issued.

Housing

Early Resolution and Voluntary Settlement

[Bron Afon Community housing Ltd - Repairs and maintenance \(inc dampness /improvements and alterations eg central heating. double glazing\)](#)

[Case Number: 201802782 - Report issued in October](#)

Mrs R complained that Bron Afon Community Housing Ltd ("the Housing Association") had failed to respond to her complaint in a timely manner; her original complaint was made in May 2016.

Although the Housing Association did provide a brief response, this failed to fully address the issues raised by Mrs R. Accordingly, in response to the Ombudsman's proposal, the Housing Association agreed to undertake the following actions in resolution of Mrs R's complaint (to be completed within one month):

- a) Apologise to Mrs R for the lack of a timely response
- b) Undertake a full review of Mrs R's complaint
- c) Provide the full response

[Pembrokeshire County Council - Repairs and maintenance \(inc dampness/improvements and alterations eg central heating. double glazing\)](#)

[Case Number: 201803031 - Report issued in October](#)

Mr A complained about work carried out to his home funded via a Disabled Facilities Grant (DFG) some years previously. Mr A had approved the Council's final payment to the contractor, whom he had engaged (as being satisfied with the work), in 2013. Thereafter, problems arose but the contractor went out of business. Mr A complained that he could not adequately use the bathroom which the DFG was meant to provide for, and he felt that the Council should remedy the work. In 2017, the Council commissioned an independent surveyor ("the Surveyor") to try to establish the root cause of the problems and identify key work required.

In light of Mr A's disability, the Council agreed to exercise discretion and carry out certain works, at its cost, to enable Mr A access to adequate bathing facilities. However, at the time of his complaint to the Ombudsman, no start date had been agreed and Mr A was dissatisfied that the Council would not carry out all works he felt were required.

The Ombudsman considered Mr A's complaint about the DFG works and the Council's inspection role as being out of time with no prospect of him being able to ascertain liability. The Surveyor had noted that the record and level of Council inspections had been beyond the norm for such a project. However, given the Council had agreed to carry out certain works, the Ombudsman felt that there had been more recent delay in progressing those in order to ensure Mr A could access adequate bathing facilities, and in keeping him informed. Accordingly, the Council agreed to the following recommendations made by the Ombudsman about that aspect of Mr A's complaint:

- a) To apologise to Mr A in writing for the delay in progress (within one month);
- b) In conjunction with the Surveyor, to prepare a schedule of works to be carried out, providing a copy of it to Mr A (within one month);
- c) In conjunction with the Surveyor, to seek and engage relevant contractor(s) within 6 weeks, and secure a start date to complete the identified works as soon as practicable thereafter. To keep Mr A updated on progress (including should any unforeseen problems arise) on a fortnightly basis.

Mid Wales Housing Association Ltd - Tenancy rights and conditions/abandonment and evictions

Case Number: 201803162 - Report issued in October

Mrs A was a former tenant of the Association having left her property many months previously when she was contacted by a debt collection agency ("the agency") acting on behalf of the Association. It said she owed the Association sums arising from it needing to carry out repair and decoration work after she had left, as well as some days rent and the cost of changing the locks (known as "rechargeables"). Mrs A disputed that she owed the sums, saying that the Association had failed to contact her at all before the agency did and had not provided any details as to how the sums were calculated (which sums had later changed). She said that hearing from the agency first had caused her distress, when she was already vulnerable. Mrs A appealed to the Association's panel and, being dissatisfied with the decision, complained to the Ombudsman.

In considering the complaint, the Ombudsman noted that Mrs A's tenancy agreement entitled the Association to recharge works that were needed after the tenancy ended. It also noted that it would involve an agency. A list of identified works had been known to Mrs A before she left. However, her son had remained in occupation beyond that. The Ombudsman could not interfere with the panel decision and Mrs A had been able to challenge any evidence at the hearing; moreover, she remained responsible for her son remaining and so rent and the charge for changing the locks were due. The Association also explained that it had taken account of Mrs A's vulnerability and written off some of the sum (hence the reduced amount), which the Ombudsman noted to be an example of good practice.

However, the Ombudsman was concerned at the lack of evidence to suggest efforts were made to contact Mrs A before the involvement of the agency. He acknowledged the distress that hearing from the agency first would have caused Mrs A. The Ombudsman also found that whilst the tenancy agreement referred to the use of an agency for collection, and the charging of an administration fee, that its Policy on recovery and recharging said nothing. He also felt the Association's letter to Mrs A was misleading, in suggesting that the Ombudsman had an appellate function in terms of deciding if the debt was owed, or not.

Therefore, the Association agreed to undertake the following:

- a) To apologise in writing to Mrs A for its initial failure to communicate directly with her about the recharges (within one month):
- b) To review the Policy and make amendments required (providing a copy of those within two months to the Ombudsman) and thereafter, within three months, to submit the Policy for Board approval. The amendments to include:
 - i) references to the Association's referral to a Debt Collection Agency
 - ii) the Association's practice of terminating direct engagement with the former tenant
 - iii) when an administration fee is chargeable to a former tenant
- c) to review the Association's standard complaint letter template regarding the reference to the Ombudsman's office (within one month).

Flintshire County Council - Applications, allocations, transfer and exchanges

Case Number: 201803551 - Report issued in November

Ms H and her child live with her mother, she has currently been on the waiting list for two years. Ms H is on the waiting list for a two bed property. She is currently in band 2 however she believes she should be band 1 priority. Ms H also mentioned that the situation could be improved if her mother was allocated a bigger property.

Ms H's concerns about the banding had been considered by the Council and the Regional Panel, and there was no evidence to suggest maladministration in respect of how the banding criteria was applied.

The Ombudsman found that although the Regional Panel responded to Ms H's concerns, the rationale for its decision could have been more fulsome, and there was nothing to suggest that the criteria for each band have been shared with Ms H.

The Council agreed to undertake the following action, within one month of receipt of the Ombudsman's decision in settlement of the complaint:

- a) Arrange for the Panel to offer a fuller explanation of its decision
- b) Share the banding criteria with Ms H
- c) Ask the Panel to record more comprehensive reasoning when recording its decision

[Denbighshire County Council - Applications, allocations, transfer and exchanges](#)

[Case Number: 201803829 - Report issued in November](#)

Ms A complained that the Council failed to take medical evidence into account when considering her housing appeal.

Ms A did not fully exhaust the Council's complaints procedure before complaining to the Ombudsman as the Council's appeal decision letter incorrectly signposted her to complain directly to the Ombudsman. The Council therefore agreed, in settlement of Ms A's complaint, to complete the following actions by 13 December 2018:

- a) Apologise to Ms A for incorrectly signposting her to the Ombudsman
- b) Consider and respond to Ms A's complaint at the final stage of its complaints procedure
- c) Pay £50 to Ms A for the time and trouble in making her complaint to the Ombudsman
- d) Ensure that all appeal decision letters correctly signpost appellants to the correct complaints procedure.

[Denbighshire County Council - Applications, allocations, transfer and exchanges](#)

[Case Number: 201803852 - Report issued in November](#)

Mr and Mrs B complained that the Council failed to take medical evidence into account when considering their appeal against the suitability of an offer of housing.

Mr and Mrs B did not complain to the Council through its complaints procedure (as required) before complaining to the Ombudsman as the Council's appeal decision letter incorrectly signposted them to complain directly to the Ombudsman.

The Council therefore agreed, in settlement of Mr and Mrs B's complaint, to complete the following actions by 13 December 2018:

- a) Apologise to Mr and Mrs B for incorrectly signposting them to the Ombudsman
- b) Consider and respond to Mr and Mrs B's complaint at the final stage of its complaints procedure
- c) Pay £50 to Mr and Mrs B for the time and trouble in making their complaint to the Ombudsman
- d) Ensure that all appeal decision letters correctly signpost appellants to the correct complaints procedure.

[Cardiff Council - Rent Smart Wales -Other](#)

[Case Number: 201804991- Report issued in December](#)

Mr V complained that Rent Smart Wales ("the Agency") had sent him threatening letters, in April 2018, regarding his failure to register rental properties. Mr V had attended one of its courses and qualified as an Agent. He had submitted a nil return via the agency's online portal as he did not have any rental properties under his management. The Agency apologised for the errors in its administration system in a letter of response to his complaint.

In November Mr V received a further 'general' text, via his mobile telephone, again advising him that he needed to review and update the properties under his management. This was unnecessary as his situation had not changed.

The Ombudsman considered that the second communication was unnecessary and contacted the Agency.

It agreed to:

- a) Write a letter to him apologising for the communication sent to him on 18 November 2018 and confirming that action has now been taken to avoid such a repeat occurrence in future.
- b) Offer a redress payment of £50 for time and trouble taken to pursue a further complaint.

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

[Caerphilly County Borough Council - Repairs and maintenance \(inc dampness/improvements and alterations eg central heating, double glazing\)](#)

[Case Number: 201804401 - Report issued in December](#)

Ms X complained that when she and her son moved into their home in 2014 various repairs were required which the Council failed to carryout.

The Council advised the Ombudsman that it had received a formal complaint from Ms X in September however, because it had no record of outstanding works, it was appropriate to deal with the complaint as a service request. The Council recognised that it failed to communicate its actions to Ms X and agreed to write a letter with an apology and a clear explanation of the reported issues and the actions it would take. The Ombudsman was pleased to note that the Council subsequently wrote to Ms X and arranged a home visit to discuss the outstanding issues.

Planning and Building Control

Upheld

Vale of Glamorgan Council - Other planning matters
Case Number: 201700223 - Report issued in October

Mr X complained about the way in which the Vale of Glamorgan Council ("the Council") managed a revised planning application for the extension of a four-bedroom property ("the Property"). The Property was located next to his own. He said that the Council had not assessed the issue of parking provision properly when considering that application. He also reported that it had inappropriately facilitated, by way of permitted development, the subsequent erection of a rear extension to the Property.

The Ombudsman found that the Council had managed the issue of permitted development correctly. Consequently, he did not uphold the permitted development element of Mr X's complaint. He also determined that it was reasonable for the Council to conclude that the extension of the Property was 'acceptable' in parking terms. However, he found that recording-related failings had compromised the

Council's ability to demonstrate that it had assessed the issue of parking provision properly. He partly upheld the parking provision aspect of Mr X's complaint as a result. He recommended that the Council should write to Mr X to apologise for the failings identified. He also asked it to send Mr X documentary evidence of the action that it had taken to address them. The Council agreed to implement these recommendations.

Caerphilly County Borough Council - Handling of planning application (other)
Case Number: 201705212- Report issued in December

Mr A complained that, having granted conditional planning permission for a local housing development, the Local Planning Authority, failed to properly discharge the associated planning conditions, resulting in his property being subject to the risk of contamination and flood water. Mr A also complained that there was a failure to adequately respond to his complaint.

The investigation found that there had been missed opportunities to ensure that the planning conditions had been met or consider taking enforcement action. The investigation also found that the Council had failed to fully respond to Mr A's complaint. The complaint was partly upheld.

It was recommended that the Council apologise to Mr A for the failings identified in this report and arrange a meeting with the Land Drainage Authority, the Highways Authority, Dwr Cymru/Welsh Water and Natural Resources Wales to formulate an action plan to address the outstanding drainage works on the site, consider the environmental impact of the unattenuated flow of water and update Mr A on the outcome. It was also recommended that, upon receipt of relevant evidence from Mr A, the Council refer Mr A's concerns about discharge leaking from the former landfill site to the Environmental Health Department for consideration and request that it undertake sampling from the stream, liaise with the water regulator and advise Mr A of the outcome of the investigations.

Early Resolution and Voluntary Settlement

Pembrokeshire County Council - Handling of planning application (other)
Case Number: 201803108 - Report issued in October

Mr D complained that the Council had failed to correctly consider aspects of its Local Development Plan in arriving at a decision to allow a planning application for a development approximately 700 metres from his home.

He also complained regarding the time that the Council had taken to escalate his complaint to stage 2 of its Complaints Procedure.

The Ombudsman was of the opinion that the planning decision by the Council did not appear to have caused him any personal hardship or injustice. He did, however, consider that there had been some delays in communication by both parties, during the complaint process.

He contacted the Council and it agreed to write a letter to Mr D advising him of the result of its investigation into his complaint.

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

[Conwy County Borough Council - Other planning matters](#)

[Case Number: 201804395 - Report issued in December](#)

Mr C complained that the Council had failed to provide a Gypsy/Traveller transit site. This did not meet its Equality Duty, it was abusing human rights and not following its statutory duties in respect of Gypsy/Travellers. The Council had also denied that he had a legitimate complaint.

The Ombudsman declined to deal with the substance of Mr C's complaint regarding the Gypsy/Traveller transit site as it is not for the Ombudsman to make a finding of a breach of statutory duty. However, he found that the Council had not dealt with Mr C's complaint in accordance with their Corporate Complaints Policy. The Council agreed to complete the following in settlement of Mr C's complaint by 31 January 2019:

- a) Apologise to Mr C for the poor complaint handling
- b) Issue a response to the substantive issues and information about Stage 2 complaint handling process
- c) Remind staff of their responsibilities under the Corporate Complaints Policy and the correct process when a complaint is raised.

[Pembrokeshire County Council - Handling of planning application \(failure to notify those affected\)](#)

[Case Number: 201804328- Report issued in December](#)

Mr X complained that the Council failed to announce on its public site that the property next door was to be built closer to his own home which would interfere with privacy. He complained that he wanted the Council to fund the cost of erecting a fence between the two properties.

During the assessment of Mr X's complaint, the Ombudsman recognised that the Council had failed to advise Mr X that it would not be considering the matter of a fence between the properties as part of its investigation, which was an integral part of his complaint. Whether a fence was actually required was not a decision for the Ombudsman.

The Council agreed with the Ombudsman that it would write to Mr X (within one month):

- a) To provide an explanation and; offer a payment of £50 for having to take the time to complain to the Ombudsman

Roads and Transport

Early Resolution and Voluntary Settlement

Caerphilly County Borough Council - Road maintenance/road building

Case Number: 201804059 - Report issued in December

Mrs B complained about the Council's failure to handle her complaint regarding potholes not being addressed, delayed waste collection and also hedge cutting. Mrs B also wished to make a claim regarding damage to her cars. Mrs B made a formal complaint to the Council however each complaint was dealt with as an informal complaint - service request. The Ombudsman found that the Council should have noted Mrs B's dissatisfaction and dealt with her concerns as a formal complaint.

The Council agreed to undertake the following actions, in settlement of the complaint, within **one month**:

- a) Apologise for failing to deal with and recognise Mrs B's contacts as complaints and issue a formal response.
- b) Inform Mrs B of details of the Council's insurers should she wish to submit a claim for damage to the cars.

Gwynedd Council - other

Case Number: 201805441 - Report issued in December

Mr D complained that the Council had failed to undertake work to clean and repair a water gully on a public footpath that was running alongside his property.

The Ombudsman contacted the Council and it agree to:

- a) Contact Mr D and give an objective of the work they intend to do and the timescales to complete the work.

This must be done within 10 working days of the date of this letter. I understand that the council has already done this.

The Ombudsman believes that this will resolve the complaint made.

Self-funding Care Provider

Early Resolution and Voluntary Settlement

Cwm Taf University Health Board - Health - Other
Case Number: 201803788 - Report issued in October

Mr B complained that the Health Board did not provide appropriate advice about how he could pursue his complaint against an Independent Care Provider.

The Health Board agreed it would write to Mr B to apologise for not providing him with advice relevant to his complaint and ensure that all staff, who may receive complaints about care delivered in nursing homes, are aware that such complaints can be referred to PSOW.

Social Services – Adult

Upheld

[Ceredigion County Council and Hywel Dda University Health Board - Services for vulnerable adults \(eg with learning difficulties. or with mental health issues\)](#)

[Case Numbers: 201703741 & 201703743 – Report issued in October](#)

Mr C complained about an adult safeguarding investigation carried out by Ceredigion County Council (“the Council”) and Hywel Dda University Health Board (“the Health Board”) into allegations of abuse Mr C had made against two members of Health Board staff. In particular, he was concerned that the correct process was not followed in conducting the investigation. In relation to the Health Board, Mr C was also concerned about its response to the outcome of the safeguarding process, including that it had not provided an apology to him.

The Ombudsman found a number of flaws in the safeguarding investigation. In particular, there was a failure to check the note of the initial interview with Mr C, which meant that some of his concerns were omitted or misunderstood. There was an informal meeting between the investigator and one of the accused staff members before a formal interview, and at times it appeared that the investigator had prompted answers from the interviewees. The explanation given for the outcome of the process could have been clearer. The Ombudsman upheld this part of the complaint. The Ombudsman also upheld the complaint against the Health Board in that it had not provided a formal apology to Mr C. The Ombudsman recommended that Mr C be provided with an apology from the bodies concerned, together with total financial redress of £750. He also made recommendations aimed at improving future practice, including the provision of training for members of Health Board staff who undertake adult safeguarding investigations.

[Ceredigion County Council - Services for vulnerable adults \(eg with learning difficulties. or with mental health issues\)](#)

[Case Number: 201705762– Report issued in December](#)

Mr B complained that the Social Services department at Ceredigion County Council (“the Council”) failed to fully meet his needs between 2009 and 2017, failed to properly take into account his disability, shared information about him without his consent, did not act on concerns about his safety, failed to investigate his complaints and is not providing care which meets his needs.

The Ombudsman mostly upheld the complaint. He found that the Council did not fully meet Mr B’s assessed needs between 2009 and 2017 and for 15 months in that time Mr B was without services at all. The Ombudsman found that the Council failed to fully consider Mr B’s safety which meant that he was potentially exposed to harm. The investigation found that Mr B and the Council had a difficult relationship and this impacted on his care needs and the way his complaints were handled.

The Council agreed to apologise for the failings identified and to pay Mr B £9500 to remedy the injustice outlined in the report. The Council also agreed to undertake a further safeguarding investigation and that it would engage a specialist to guide it in the assessment of Mr B’s needs in future.

Not Upheld

[Merthyr Tydfil County Borough Council - Adult Social Services - Services for People with a disability inc DFGs](#)

[Case Number: 201706115 - Report issued in October](#)

Ms Y complained that the Council unreasonably denied her access to be considered for a Disabled Facilities Grant (“DFG”) and in particular, that there was an inappropriate delay in arranging for an

assessment by a Community Occupational Therapist ("COT"), to enable the progression of a DFG application. Consideration was given as to whether the Council had appropriate regard to Ms Y's human rights and whether it had communicated in a clear and transparent manner about the timescales for undertaking a COT assessment.

The investigation found that Ms Y had to wait an extended period for a COT assessment, due to the high demand on the service and the prioritisation of need. There is no evidence to suggest that the Council did not apply its procedures properly in this case, or that it failed to have regard for Ms Y's human rights. The investigation identified that it may have been more helpful for the Council to have informed Ms Y from the outset about the potential waiting time for an assessment, but when she sought clarity about the timescale, the Council responded appropriately. The complaint was not upheld.

Early Resolution and Voluntary Settlement

Cardiff Council – other

Case number: 201801562 – Report issued in October

Miss A complained about the withdrawal by the Council of social work support from her son, without any assessment of his needs taking place. Miss A also complained that her own needs had never been assessed by the Council. Miss A was also concerned that her complaint was not dealt with in a timely manner or in accordance with her requests for advocacy support and privacy.

Although the Ombudsman decided not to investigate the complaint, the Ombudsman was concerned about the matters raised by Miss A.

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

- a) To complete an assessment of Miss A's needs for support, and put in place any identified support;
- b) To offer Miss A a payment of £750 for failing to assess her needs for support for eighteen months;
- c) To apologise to Miss A for failing to send an easy read complaint form;
- d) To offer Miss A a payment of £125 for the time and trouble she experienced in bringing her complaint to the Ombudsman.

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

Case Number: 201804152 - Report issued in November

Mr B complained that his wife's social care package of support (30 hours per week over the last 11 years) to assist her with her day to day activities was cut. Mr B was unhappy about losing half of Mrs B's care package and made a complaint about the cut in hours.

The Ombudsman contacted the Council who acknowledged the complaint and explained that it would carry out a reassessment of Mrs B by a different team with different management responsibility.

The Ombudsman considered that this action was reasonable and the Council agreed to undertake the following in settlement of the complaint (within one month):

- a) Apologise to Mr B for the delay
- b) Provide the Stage 2 Social Services Policy and Procedure to Mr B should he wish to escalate the complaint
- c) Reassess Mrs B's care needs.

Social Services – Children

Not Upheld

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

Case Number: 201708106 - Report issued in October

Ms F complained that Conwy County Borough Council ("the Council") failed to follow appropriate safeguarding procedures in response to concerns she had raised about the safety and wellbeing of her grandchildren. Ms F said that the Council had not taken her concerns seriously, and particularly that it had failed to refer incidents of abuse to the police, interview relevant witnesses and ensure that her Grandchildren's interests were protected.

The Ombudsman found that the Council should have made a referral to the police, but that there was no detriment to the investigation because Ms F had reported her concerns to the police directly, and an investigation was subsequently progressed appropriately. He considered that, in the context of the nature of the safeguarding reports, it would not have been proportionate or justified to interview the children, which might have caused them emotional upset or distress. Similarly, it was not necessary to interview anyone from outside of the family, which might also have compromised the family's confidentiality by revealing that Social Services were involved with them. The Ombudsman **did not uphold** the complaint.

Early Resolution and Voluntary Settlement

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

Case number: 201803439 - Report issued in October

Ms B complained that the Council acted unreasonably by inviting her to attend a Public Law Outline ("PLO") meeting, at which she was asked questions, but was not given a full opportunity to respond.

Although the Ombudsman declined to investigate Ms B's complaint, he was concerned that the letter sent to Ms B inviting her to attend the PLO meeting suggested that Ms B would be asked to speak, but when Ms B attended the meeting, she was informed that the meeting was not a forum for discussion.

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

- a) To write to Ms B to apologise for the way in which she was made to feel, by being instructed that the PLO meeting was not an opportunity for discussion;
- b) To review the standard letters sent to parents and family members as part of the PLO process to ensure that they comply with Welsh Government guidance.

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

Case Number: 201803610 - Report issued in October

Mr A complained about the actions of Council social workers in relation to his grandchildren. The Council had declined to deal with his formal complaint as there were pending court proceedings. In his complaint to the Ombudsman, Mr A sought the dismissal of the staff concerned as well as the consideration of his complaint.

The Ombudsman could not consider Mr A's main complaint as he could bring up the issues within the proceedings; moreover, the dismissal of staff was not a remedy the Ombudsman could achieve. However, the Ombudsman found that the Council's letter to Mr A was deficient. Whilst correctly notifying him it could not consider his complaint whilst there were pending proceedings, it failed to notify Mr A (as

Guidance required) that he could re-submit his complaint when those proceedings were concluded. Therefore, the Ombudsman contacted the Council and it agreed to undertake the following (within one month):

Apologise to Mr A in writing, for the failure identified and to provide him with the required information.

[Cardiff Council - Children in care/taken into care/'at risk' register/child abuse/custody of children](#) [Case Number: 201802886 - Report issued in October](#)

Mrs A complained that she had not received financial assistance from the Council following her niece's placement with her in November 2016. She said she was informed that she would receive the same payments as a foster parent. However, despite contacting the Council about this and chasing the matter for over one year, the Council had not responded to her request.

The Ombudsman contacted the Council as the evidence suggested that Mrs A ought to have been provided with financial assistance and it had failed to respond to her request. It agreed to carry out the following, within one month of the decision letter, in settlement of the complaint:

- a) To provide an apology to Mrs A for the failure to respond to her request for financial assistance
- b) To provide Mrs A with a payment of £250 in recognition of the time and trouble caused to her due to the failure to respond to her request
- c) To calculate the amount of financial assistance due to Mrs A and provide her with this backdated payment.

[Flintshire County Council - Social Care Assessment](#) [Case Number: 201804056 - Report issued in November](#)

Ms B complained that the Council had not dealt with her earlier complaint or with the allegation of an assault suffered by her teenage daughter (D). It had said that D would be assessed but this had not taken place, and the Council had closed its file concerning the matters.

The Ombudsman normally expects a complainant to have progressed through the full complaints process, but was concerned that D (being in her teens) should have been told independently about the decision to close the case on her allegation. The Ombudsman contacted the Council and it agreed to undertake the following actions, which he felt to be a reasonable resolution of the complaint made to him:

- a) To apologise to D for failing to consider her needs independently and failing to communicate the decision to close her case directly to her (within one month);
- b) To undertake D's assessment and investigate her concerns as soon as practicable (in any event within 3 months);
- c) To consider and respond (at Stage 1) to Ms B's complaint in writing (directly or through an advocate) within 30 days, informing her of her right to progress to a Stage 2 investigation if dissatisfied with that response.

[Powys County Council – Other](#) [Case Number: 201801288 - Report issued in November](#)

Mr A and his wife were Special Guardians to two young people. He complained that the Council failed to fulfil its duties to them and the young people, both during and on expiry of the Special Guardianship Orders. The investigation into this complaint was discontinued when, the Council agreed to settle the complaint by making a payment of £25,375, which was requested by Mr A.

[Bridgend County Borough Council — Other](#) [Case number: 201804304 – Report issued in December](#)

Miss A complained that the Council placed a young person ("B") in her care under a full Care Order without Miss A being approved as a foster carer, and without providing Miss A with an explanation of the terms or responsibilities that this entailed, and without providing any financial assistance to Miss A.

The Ombudsman was concerned that this placement may have been illegal because B was subject to a full Care Order. For that reason, he contacted the Council who confirmed that the issues had occurred due to an administrative oversight and offered sincere apologies to Miss A.

The Council also agreed to:

- a) Take appropriate steps to ensure that B's placement with Miss A was not illegal, including retrospective approval of Miss A as a temporary foster carer;
- b) Make a payment to Miss A in line with what she would have received had she been approved as a temporary foster carer;
- c) Assess Miss A and B's circumstances to determine whether they were entitled to any other services or payments from the Council, and to confirm this to them.

Caerphilly County Borough Council - Social Care Assessment

Case Number: 201804688 – Report issued in December

Miss A complained on behalf of X about the Council's refusal to progress X's complaint to Stage 2 under its Social Services complaints procedure when requested by X.

The Ombudsman contacted the Council because he was concerned that under the relevant regulations, it is obliged to progress complaints to Stage 2 once a request is made. The Council agreed to carry out the following in settlement of the complaint:

- a) Within one month, provide an apology to X for the failure to progress his complaint to Stage 2 of the process
- b) Within three months:
 - i) Investigate X's complaint under Stage 2 of the process
 - ii) Remind relevant staff of the obligation to consider similar requests under Stage 2
 - iii) Carry out an audit check to identify whether any requests within the last six months have been similarly refused and take steps to ensure they are progressed to Stage 2.

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

Case Number: 201805179 – Report issued in December

Mrs A complained that the Council had failed to respond to all aspects of her complaint about Children's Services.

The Ombudsman found that the Council had failed to progress Mrs A's complaint to Stage 2. Under the relevant regulations, it is obliged to progress complaints to Stage 2 once a request is made. The Council agreed to carry out the following in settlement of the complaint **by 22 January 2019**:

- a) Investigate Mrs A's complaint under Stage 2 of the Complaints Procedure
- b) Remind relevant staff of the obligation to consider similar requests under Stage 2 of the process
- c) Make a payment of £50 to Mrs A for the time and trouble in making her complaint to the Ombudsman

Various Other

Upheld

Abertawe Bro Morgannwg University Health Board - Other miscellaneous

Case Number: 201705337 - Report issued in October

Mr Y complained that he received traditional open surgery to treat a hernia (when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall), when he believed that he was going to undergo a laparoscopic repair (keyhole surgery). Mr Y said that he did not give consent to open surgery.

The Ombudsman found that the evidence clearly reflected that Mr Y did not wish to undergo open surgery and had waited an extra nine months to undergo laparoscopic surgery. It was unclear what information was provided to Mr Y during any of his pre-surgery appointments and there were no clinical notes to support that a meaningful conversation had taken place with Mr Y to discuss the possibility of converting to open surgery. The Ombudsman found that that the possible need to revert to open surgery should have been recorded on the consent form as a possible risk and that, if the risk of converting to open surgery had been clearly explained to Mr Y, he might have concluded that the surgery was not for him at that time or sought further information before making the decision to proceed.

The Ombudsman upheld the complaint and recommended that the Health Board apologise for the failings identified and make a financial redress payment of £500 to Mr Y. He also recommended that the Health Board should remind its surgical clinicians of their duty to conduct and record pre-operative consent processes in accordance with the Consent Policy, and confirm that the clinicians identified within this report have had an opportunity to reflect on its findings and conclusions.

[Betsi Cadwaladr University Health Board - Poor/No communication or failure to provide information](#) [Case Number: 201800184 - Report issued in November](#)

Mr X complained about the Health Board's decision to impose restrictions on his contact with it, and its subsequent failure to respond to his correspondence.

The Ombudsman found that the Health Board did not, at the time, have a policy for dealing with what it considered to be unreasonable behaviour of, or unreasonable demands made by, an individual. This meant that there was no process for formally reviewing the decision to restrict Mr X's contact. The Ombudsman upheld the complaint, and recommended that the Health Board introduce such a policy and, thereafter, review the restrictions imposed on Mr X's contact in accordance with the policy.

[Early Resolution or Voluntary Settlement](#)

[Cadwyn Housing Association Ltd - Other miscellaneous](#) [Case Number: 201708048- Report issued in December](#)

Miss A complained that Cadwyn Housing Association Ltd's ("the HA") investigation into her complaint was inadequate, superficial and lacked transparency. She was also dissatisfied that the HA had lost key information relating to her complaint.

The Ombudsman identified that whilst the HA had taken measures internally to address shortcomings in its physical adaptation grants ("PAG") process, its handling of Ms A's complaint had not been sufficiently robust. This had led it to reach erroneous conclusions including around 'lost' documentation. The Ombudsman highlighted the need for complaint investigations to be objective, transparent and open. He was not satisfied that the HA's actions had always been consistent with the good administration guidance that he had issued to bodies in his jurisdiction.

In arriving at a settlement with the HA, the Ombudsman requested that the HA undertake various PAG related actions including post-inspecting the works carried out at Miss A's property. In addition, the HA agreed to apologise to Miss A and make a payment of £500 in recognition of the distress its failings had caused.