

# The Ombudsman's Casebook

Issue 36 January – March 2019

## News

### New Powers for the Ombudsman

We are pleased to announce that the Public Services Ombudsman (Wales) Act 2019 received Royal Assent in May 2019.

The Act will extend the Ombudsman's powers to enable him to:

- Conduct investigations on his own initiative
- Launch a Complaints Standards Authority for Wales
- Investigate some aspects of private health care
- Accept complaints made other than in writing



Aspects of the new powers relating to 'own initiative investigations' and the Complaints Standards Authority will be open to public consultation later this summer – please see our website for further details about how you can participate in the consultation in the coming months.

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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.

Cardiff and Vale University Health Board - Clinical treatment in hospital  
Case Number: 201706982- Report issued in January 2019

Mr A complained that while his mother, Mrs A, was admitted to hospital following a fall in May 2017, the Health Board failed to adequately assess and treat her symptoms of slurred speech, lethargy and fits and that it incorrectly administered an antidote for a morphine overdose. He also complained that the Health Board failed to deal with his safeguarding concerns appropriately, particularly in relation to bruising to Mrs A's elbow. He further complained that the Health Board did not deal with his formal complaint reasonably and had failed to provide him with information he had requested.

The Health Board had lost Mrs A's health records for a significant period of her care. However, Mr A had already obtained a copy, which the Ombudsman was able to use to inform his investigation and findings. The Ombudsman found that the Health Board failed to identify that Mrs A had acute kidney failure from the time she was admitted. In an attempt to control Mrs A's back pain, she was prescribed pain relief at inappropriate levels (in the context of her kidney failure) and, even when she began to decline, this was not reviewed. The failure to monitor Mrs A's medication and kidney function resulted in an acute kidney injury, which was probably preventable but was overlooked and, ultimately, precipitated her death. The prescription of the antidote was appropriate to counter the accumulation of opioid pain killers, which could not be filtered from Mrs A's blood by her damaged kidneys. However, it was prescribed too late, which led to uncertainty about whether it might have had any effect if it had been prescribed sooner.

The Ombudsman accepted the ultimate outcome of the safeguarding investigations, which found that the bruising to Mrs A's arm had been caused by a manual handling accident when Mrs A was assisted to move up the bed. However, there had been significant delays in the reporting, processing, investigating and managing of Mr A's safeguarding concerns. Additionally, the Health Board had failed to process Mr A's complaint in line with its complaints process, Putting Things Right ("PTR"), or keep him updated on progress of the investigation in line with that procedure.

The Health Board had identified, during the course of its own investigation, that Mr A's complaint was not processed correctly, and that communication with him had been poor; it suggested to me that it would offer Mr A £750 in recognition of these failings. Following my investigation, the Health Board agreed to undertake the following actions:

Within one month of the date of this report:

- (a) Provide a full and meaningful apology for all the failings identified in this report
- (b) Offer Mr A £750 as suggested by the Health Board for the complaint handling failures
- (c) Offer Mr A £500 for the failure to progress the two Safeguarding Referrals appropriately and £250 for the loss of Mrs A's medical records
- (d) Offer Mr A further financial redress of £4,000, to reflect the failure to assess, diagnose and treat Mrs A's condition and in recognition of the uncertainty as to whether remedial action might have prevented her death, as well as the distress caused to Mr A and his family in the manner of her death.

Within three months of the date of this report:

- (e) Undertake a quality improvement project to consider the e-handover system for sharing information about a patient's condition, medication, and any notable changes or deterioration in their presentation when they are moved in a planned move between wards. Where any shortcomings are identified an action plan should be put in place, to address them.
- (f) All staff involved in this case should receive training on reporting and handling of injuries sustained during hospital admission, including receiving and processing of both Safeguarding Referrals and complaints raised under PTR and how each should be progressed. This should include guidance on the value of each of those processes, the importance of full and transparent record keeping, and the consequences of carrying prejudices against patients and their families after any such report or Safeguarding Referral has been made.
- (g) All staff involved in complaint handling on this case should be reminded of the role of the Concerns Team, which should ensure that investigations are concluded in a timely manner and that complainants are kept informed, in accordance with PTR.
- (h) The Health Board should provide the Ombudsman with evidence that it has adequate arrangements in place for senior medical review on weekends and bank holidays for Geriatric Care.

Within six months of the date of this report:

- (i) All doctors involved in this case and any other relevant clinicians should undergo further training, with particular reference to current NICE and professional guidelines, on recognition of sepsis and the risk of AKI, as well as drug dosing and toxicity in elderly patients and those with kidney disease.
- (j) All doctors involved in this case should evidence a reasonable level of reflection upon the issues raised in this complaint, with particular reference to the themes set out in the analysis section of the report, including discussion of the matter at their next appraisal. The Health Board's Medical Director should also review the report and consider whether any of the issues raised warrant referral of any relevant clinician to the GMC.

## Health

### Upheld

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201705590 – Report issued in January 2019

Ms B complained to the Ombudsman that Cwm Taf University Health Board ("the Health Board") failed to investigate and adequately respond to a complaint that she made about the care that her late mother, Mrs C, received following her admission to Prince Charles Hospital. Mrs C, who had been diagnosed with lung cancer some months before, rapidly deteriorated during her admission and sadly, passed away. Ms B subsequently complained to the Health Board about numerous aspects of the nursing care her mother received and in response, was invited to attend a meeting with Health Board personnel. At this meeting an undertaking was given that a number of identified failings would be discussed with the relevant nursing staff, and measures would be introduced to prevent their recurrence. However, Ms B complained to the Ombudsman that:

1. Whilst the Health Board provided notes of the meeting, it failed to formally respond to her letter of complaint and failed to provide evidence of the actions that the family was assured would be taken in response to their concerns.
2. Following a further complaint from the family about this, a formal complaint-response letter and an action plan were produced by the Health Board. However, Ms B considered these inadequate and incomplete.
3. During her admission, physicians failed to discuss, review and possibly revise Mrs C's Do Not Attempt to Resuscitate (DNAR) order, despite a CT scan identifying a reduction in the size of her cancerous mass.

The Ombudsman upheld complaints 1 and 2 and partially upheld complaint 3. The Ombudsman recommended that the Health Board provides Ms B with a fulsome written apology for the failings identified and makes a payment to Ms B of £250 in recognition of the time and trouble to which she was put as a result.

The Ombudsman also recommended that staff are reminded of the technical requirements of action plans (that, within an agreed timeframe, they provide robust evidence of actions completed) and that the Health Board provides Ms B (and the Ombudsman) with an account of how the failings in nursing care that the Health Board has acknowledged in this case (but which did not appear in the action plan) have been or will be addressed by the staff concerned.

Finally, the Ombudsman recommended that clinicians are reminded that it is good practice to review and discuss DNAR orders with patients and family members and to ensure that the decision to refer patients for palliative care and/or embark on end-of-life care is clearly communicated and understood by patients and their relatives.

The Health Board accepted and agreed to implement these recommendations.

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

[Case Number: 201706821 – Report issued in January 2019](#)

Mrs A complained about the care and treatment her late husband, Mr A, received from the Betsi Cadwaladr University Health Board ("the Health Board"). Mrs A complained that there was a delay in diagnosing Mr A's cancer. Mrs A also complained that there had been a failure to provide adequate nutritional and speech and language therapy ("SALT") support as well as a failure to provide appropriate pulmonary rehabilitation support.

The investigation found that, whilst there was no evidence that there had been a delay in diagnosing Mr A's cancer, there had been missed opportunities to refer Mr A for dietary and SALT support. The investigation also found that, despite referrals being made to the Pulmonary Rehabilitation Team and the Pulmonary Rehabilitation programme, there was very little input from either.

It was recommended that the Health Board apologise to Mrs A for the failings identified in the report and pay her £725 in recognition of the delays experienced and the poor pulmonary rehabilitation support identified. It was also recommended that the Health Board remind clinicians of the need for a Malnutrition Universal Screening Tool assessment when a patient is admitted and to consider referring patients to the Dietician or SALT for review on admission.

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

[Case Number: 201703299 – Report issued in January 2019](#)

Ms X complained about the care given to her late father, Mr Y, by Betsi Cadwaladr University Health Board ("the Health Board"). She said that the Health Board had failed to address Mr Y's nutritional needs properly, to monitor his overall condition effectively, to respond appropriately to the family's concerns about his physical health and to detect the early signs of his bowel damage.

The Ombudsman could not establish that the Health Board had failed to respond to the concerns that Mr Y's family had had about Mr Y's physical health. Consequently, he did not uphold the concern-related element of Ms X's complaint. The Ombudsman found that the Health Board's management of Mr Y's nutritional care had been poor. He determined that it had failed to monitor Mr Y's condition appropriately. He confirmed that the diagnosis of Mr Y's bowel injury had been delayed. He upheld the nutrition, monitoring and detection-related parts of Ms X's complaint as a result. He recommended that the Health Board should write to Ms X to apologise for the failings identified and to outline what it had done and what it would do, to stop them from being repeated. He also asked the Health Board to give Ms X documentary evidence of the action that it had taken in response to those failings. The Health Board agreed to implement these recommendations.

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

[Case Number: 201705671 – Report issued in January 2019](#)

Mr Y complained about the treatment that his late son, Mr X, received at Ysbyty Glan Clwyd between 18 and 20 March 2016. Mr X was 23 years old and suffered from Duchenne muscular dystrophy (a muscle wasting condition). On 18 March, Mr X was taken to hospital by ambulance and initially diagnosed with respiratory and urinary tract infections. It was noted that he had had a nose bleed since the morning and he had blood clots in his nostrils. On 20 March, at ICU a Physiotherapist attempted a left nasal suction to clear chest secretions. Mr X started to bleed heavily from the same nostril, and later sadly died. Mr X's cause of death was recorded as acute airway obstruction due to epistaxis (nose bleed), acute pancreatitis and Duchenne muscular dystrophy.

The Ombudsman found that the record of Mr X's previous nosebleed had not been transcribed from his medical notes to the ICU notes and the Physiotherapist was unaware of this. The Ombudsman also found that there was a failure to have explained the procedure and to account for using a larger than usual catheter for the nasal suction. The complaint was upheld. The Health Board agreed to implement the Ombudsman's recommendations and apologise to Mr X's family, make a redress payment of £1000, inform the Ombudsman of steps taken to prevent a repetition of notes not being transcribed to ICU notes and review whether a Microbiologist is available for similarly complex patients.

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

[Case Number: 201705908 – Report issued in January 2019](#)

Ms X complained about the treatment her 13 year old daughter, Child A, received between 3 and 8 November 2016 at Royal Gwent Hospital. Child A's GP referred her with suspected appendicitis. Ms X complained that Child A's appendicitis was misdiagnosed as gastroenteritis and there was a five day delay before her daughter had an ultrasound scan. On 9 November, Child A had surgery to remove her appendix.

The Ombudsman found that Child A's GP referral was overlooked after the initial assessment, her abnormal indicators were not consistent with a diagnosis of gastroenteritis and there was no screening test for sepsis. He found that the clinicians maintained the original diagnosis of gastroenteritis despite contradictory signs. The Ombudsman also found that on 5 November when Child A's symptoms were possibly appendicitis there was a lack of urgency to arrange an ultrasound scan and the 6 November X-ray which showed dilated small bowel loops was given limited consideration. The Ombudsman upheld the complaint. The Health Board agreed to implement the Ombudsman's recommendations to apologise to Ms X and Child A, make a redress payment of £2500, remind clinicians to write differential diagnoses and not to become fixated on a single decision, and remind paediatricians that appendicitis does not always present with typical symptoms of appendicitis.

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

[Case Number: 201706558 – Report issued in January 2019](#)

Miss X complained that despite her father's ("Mr Y") unstable condition following his admission to Royal Gwent Hospital in 2017, cardiac monitoring was discontinued after three days and staff did not take into account her father's symptoms (palpitations, shortness of breath). Miss X was also concerned that there was a delay in carrying out planned coronary angiography, which was initially cancelled. She said that when the angiography was undertaken, Mr Y was found to have left coronary artery disease and required bypass surgery. Despite being transferred to another hospital for surgery, he sadly died. Miss X was concerned that the delay in carrying out coronary angiography affected her father's treatment.

The Ombudsman did not criticise the decision to stop continuous cardiac monitoring; however, he did criticise the delay in carrying out the angiography, particularly as Mr Y's condition had been unstable in the meantime. The Ombudsman found, however, that the delay in carrying out angiography did not affect the sad outcome. He therefore only upheld the complaint to the limited extent of the uncertainty and frustration the family were caused by the delay. He recommended that the Health Board should apologise to Miss X and develop a protocol for prioritising patients requiring coronary angiography.

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

[Case Number: 201800503 – Report issued in January 2019](#)

Mr C complained about the care provided to his adult daughter, Ms C, following her injury in an accident in November 2017. Specifically, Mr C was concerned that when Ms C was seen in outpatients, the Consultant Trauma and Orthopaedic Surgeon who saw her ("the First Consultant") apparently was initially unaware that she had fractured her pelvis and that, by manipulating her legs, the First Consultant may have exacerbated her injury. Mr C was also concerned about the actions taken by the Health Board to establish whether there was a third fracture to his daughter's pelvis. Finally, Mr C was dissatisfied with the Health Board's response to his complaint.

The Ombudsman considered that it was clinically appropriate for the First Consultant to have carried out the examination he did. However, he criticised the standard of communication at this consultation, which affected Ms C's confidence in her subsequent treatment. To that limited extent he upheld that part of the complaint. The Ombudsman did not uphold the complaint about the actions taken by the Health Board to establish whether there was a third fracture, as these were appropriate. The Ombudsman found that the Health Board's response to Mr C's complaint was generally satisfactory, other than that there was a minor factual error in the letter. To that limited extent only, he upheld that part of the complaint. The Ombudsman recommended that the Health Board apologise to Ms C and Mr C for the failings identified.

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

[Case Number: 201705067 – Report issued in January 2019](#)

Mr X complained about Aneurin Bevan University Health Board's ("the Health Board") care of his late grandfather, Mr Y, in particular, that there was a delay in reviewing and acting on his vascular problem in October – December 2015, and that he was discharged home without adequate assessment, support or equipment. Mr X said that as a result, his grandfather had to sleep in a chair and use a bucket as a lavatory as he could not manage the stairs. Mr X was also dissatisfied with the Health Board's handling of his complaint.

The Ombudsman did not uphold the complaint about the treatment of Mr Y's vascular problem, which was appropriate. He found that whilst it was clinically appropriate for Mr Y to have been discharged home, he was not assessed beforehand by an occupational therapist. Had that occurred, it was possible that a commode or other equipment would have been provided. He upheld that part of the complaint. The Ombudsman partly upheld the complaint about the Health Board's handling of the family's complaints. Whilst the Health Board's initial response was reasonable, its response to a second complaint was delayed and contradictory messages were given about what was happening. The Ombudsman recommended that the Health Board apologise to Mr X and review and audit discharge planning documentation on the ward concerned.

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

## Case Number: 201707625 – Report issued in January 2019

Mr X complained that he had waited an inappropriate length of time (96 weeks) for knee replacement surgery which had been deemed urgent by the Consultant Orthopaedic Surgeon. Mr X also complained that the Health Board failed to undertake a thorough investigation of his complaint.

The investigation found that there had been a failure to meet the Welsh Government referral to treatment time target of 36 weeks, however Mr X did not come to any clinical harm as a consequence. There was no doubt that Mr X suffered unnecessary pain and discomfort for a prolonged period of time however the pain and suffering was not over and above any other patient in a similar state of arthritis. This aspect of Mr X's complaint was not upheld.

The investigation found that the Health Board failed to comply with the statutory guidance on complaint handling and this amounted to maladministration. The generalised responses Mr X received from the Health Board caused him to feel that his complaint was not being taken seriously or investigated thoroughly and this represented an injustice to Mr X. The Health Board agreed to apologise to Mr X, offer a payment of £250 for his time and trouble in pursuing the complaint and provide training to its Complaints Team.

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

### Case Number: 201800604 – Report issued in January 2019

Mr Y complained about the care and treatment provided to his late father (Mr X), by clinicians at a hospital based within the Health Board between 3 and 8 August 2017.

The investigation found that Mr X was admitted to the most appropriate ward and it was not unreasonable that he was not referred to a Cardiologist during his admission.

The investigation was unable to determine whether the information surrounding Mr X's death was shared sensitively with the family.

The investigation found that the management of Mr X's diagnosed cardiac difficulty was not reasonable. In addition, it was unreasonable that the Ward Doctor failed to review Mr X following the family sharing their concerns. Furthermore, the investigation found that the record keeping of clinicians on 8 August was not of a reasonable standard. Finally, the investigation found that the Health Board did not satisfactorily deal with Mr Y's complaint.

The Health Board agreed to provide an apology to Mr Y for the failings identified and a redress payment of £250. In addition, it agreed to remind staff of the procedure for requesting urgent echocardiograms, provide record training to the staff involved in Mr X's care on 8 August, remind doctors within their Quality Safety Experience meeting of their duties to work in partnership with patients and their relatives and remind the Ward Doctor to use the complaint and report outcome as a source of personal reflection which can be discussed in his annual appraisal.

## Deeside Medical Centre - Clinical treatment outside hospital

### Case Number: 201802836 – Report issued in January 2019

Mrs X complained about the care and treatment that her late mother ("Mrs Y") received from a GP ("the GP") based within the Medical Centre during a home visit on 25 June 2018. In particular, Mrs X said that, contrary to advice provided by the Out of Hours GP ("OOHGP") on 23 June, the GP declined to prescribe Mrs Y with steroid medication and protein drinks. In addition, Mrs X said that Mrs Y was not treated with compassion and respect by the GP.

The investigation found that there was no record of a discussion regarding the need for protein drinks or oral steroid medication in the clinical notes of the OOHGP's consultation. The GP acted appropriately on 25 June in not prescribing protein drinks to Mrs Y and acted within the range of appropriate clinical



practice in not prescribing additional steroid medication.

The investigation found that whilst it was appropriate for the GP to advise Mrs X that Mrs Y may not fully recover and regain independence, it was not appropriate for this discussion to be held with Mrs Y in the room. It was impossible to determine whether the GP lacked compassion in the manner she delivered the information. This aspect of Mrs X's complaint was upheld however as the GP had already apologised to Mrs X and had informed the Ombudsman that she had learnt from the incident, there was nothing further that could be recommended.

## St John's Cymru – Wales - Clinical treatment outside hospital

Case Number: 201707726 – Report issued in January 2019

Mr A complained about the care provided to his late mother, Mrs B, by St John Cymru – Wales ("SJCW") who provided Mrs B with transport services on behalf of Welsh Ambulance Services NHS Trust ("WAST"). The investigation considered whether the decision by WAST to send SJCW to convey Mrs B to hospital was appropriate, the way SJCW managed the transfer, and whether there were any failings which resulted in Mrs B fracturing her leg, and the investigation of Mr A's concerns by both organisations.

The Ombudsman was satisfied that the decision by WAST to send SJCW was appropriate and one it was entitled to take. He did not uphold this complaint.

The Ombudsman was unable to reach a view on what most likely happened when SJCW transferred Mrs B and whether this caused a fracture, and there is a dispute about whether Mrs A was 'dropped' or lowered to the floor in a controlled manner. However, he found that the failure to document the fall or report it to the hospital, regardless of the mechanics of how it happened, was a service failure. He upheld the complaint to the extent there was a failure to document the fall which may have delayed precautionary X-rays and earlier diagnosis and treatment of Mrs B's fracture. He made a number of recommendations to SJCW, including an apology.

The Ombudsman found that whilst Mr A was concerned that neither WAST nor SJCW visited the home to examine the layout of the room or interviewed him as a significant witness, neither body acted outside the expectations of the relevant complaint handling regulations in this regard in investigating Mr A's complaint. He did not uphold this complaint.

## Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201707634 – Report issued in January 2019

Ms M complained about the care provided to her father, Mr M, while a patient at Prince Charles Hospital, in particular that:

- He sustained a fall, resulting in a broken hip
- There was a delay in diagnosing and treating the injury
- Records regarding the administration of ibuprofen cream were incorrect.

Ms M also complained about the delay in the Cwm Taf University Health Board ("Health Board") responding to her complaint.

The Ombudsman found that Mr M's falls assessment had not been completed correctly, but he could not say for certain that Mr M's fall could have been prevented. The incident was not recorded correctly, and there was a delay in a doctor being called to examine Mr M and thus a delay in an X-ray being carried out and Mr M's fracture being identified and treated. However, this did not necessarily mean that the corrective surgery would have been carried out sooner. The Ombudsman upheld the complaints regarding the fall and Mr M's diagnosis and treatment thereafter, but not the complaint regarding the delay in responding to the complaint. He could not reach a conclusion about the administration of ibuprofen cream as the records differed from Ms M's recollection.

The Ombudsman recommended that the Health Board apologise to Mr M, make a redress payment of £500 in recognition of the distress and uncertainty caused, and made recommendations about the review of relevant Health Board guidance.

## [Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201704809 – Report issued in January 2019

Ms A complained about an operation carried out to remove an ovarian cyst, which led to one of her ovaries being removed. In particular, she was concerned about whether the operation should have gone ahead before her fertility treatment, and about how and when the risks were explained to her beforehand. Ms A also complained that the complaint response letter from Betsi Cadwaladr University Health Board (“the Health Board”) was sent to an incorrect address.

The Ombudsman’s investigation found that the referral for surgery was appropriate and that the operation was carried out to an acceptable standard. The investigation also found that the removal of one ovary was unlikely to have jeopardised Ms A’s fertility treatment and that she consented to the operation going ahead after the risks had been explained to her. These elements of the complaint were therefore not upheld. The investigation did however uphold the complaint that the Health Board’s complaint response was sent to Ms A’s previous address even though her records had been updated. The Ombudsman recommended that the Health Board apologise to Ms A for this failing.

## [Aneurin Bevan University Health Board - Clinical treatment outside hospital](#) Case Number: 201703735 – Report published in February 2019

Miss X complained about the care she received during her pregnancy, regarding additional scans and tests she felt were necessary. Miss X also complained about the failure to advise her to attend hospital for clinical assessment when she telephoned to express concern at reduced foetal movement. Miss X’s baby was later stillborn.

The Ombudsman found that the approach taken in respect of investigations during Miss X’s pregnancy were appropriate and did not uphold these complaints. However, the Ombudsman found that the failure to properly advise Miss X was a significant failing. Whilst the Ombudsman was unable to definitively say that the sad outcome would have been avoided, Miss X was left with this uncertainty. The Ombudsman therefore upheld this part of the complaint. The Ombudsman recommended that the Health Board should apologise to Miss X and use her case as a learning tool.

## [Cwm Taf University Health Board & Ashgrove Surgery - Clinical treatment in hospital](#) Case Number: 201800818 & 201800819 – Report published in February 2019

Mr X complained that the Radiologist failed to take his mother, Mrs A’s, medical history and complaints of back pain into account during a scan. He also complained that there had been a failure to properly consider his complaint.

Mr X complained that the GP Practice failed to adequately treat Mrs A’s spinal fracture and failed to communicate with her about the care and treatment of the injury. Mr X also complained that there had been a failure to appropriately consider his complaint.

With respect to the Health Board, the investigation found that, despite concerns about back pain being raised prior to the scan, no adjustments were made to meet Mrs A’s needs. It also found that the Health Board’s complaint response addressed the clinical matters that had been raised.

With respect to the GP Practice, the investigation found that, whilst earlier diagnosis of the spinal fracture would not have changed the treatment plan, there was a delay in making the diagnosis. It also found that the GP Practice had failed to provide Mrs A with sufficient information about her injury and treatment plan. Finally, the investigation found that the GP Practice’s complaint response addressed the clinical

matters that had been raised.

It was recommended that the Health Board apologise to Mrs A and undertake a review of its process and documentation for frail patients during the scanning process.

It was recommended that the GP Practice apologise to Mrs A and undertake a review of the findings of this report.

## Welsh Ambulance Services NHS Trust - Ambulance Services Case Number: 201707988 – Report published in February 2019

Mr X complained about the circumstances surrounding his father, Mr Y's wait for an ambulance on 2 December 2017. Mr Y was 96 years old, he fell and was bleeding from his head, and called for an ambulance. The Ombudsman found that when Mr Y first called there was an ambulance available within the locality which was not despatched to him, and he had an unacceptable wait of over four hours for an ambulance. He also found that Mr Y had not received a welfare call in a timely manner and that it was only after a clinician called him that a search for an available ambulance was made.

WAST agreed to implement the Ombudsman's recommendations and apologise to Mr X and Mr Y for the identified failings, review why an available ambulance was not identified, explain why it happened and the steps taken to prevent a repetition, and review its processes to ensure that timely welfare calls are made where appropriate.

## Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number: 201707540 – Report published in February 2019

Mr A complained about the treatment and care provided by the Health Board for his late wife, Mrs A. He raised concerns about delay in diagnosing Mrs A's lung cancer from 2015, poor complaint handling and failing to provide Mrs A's complete health records when requested.

The Ombudsman found that there were delays in Mrs A's management from late November 2016, causing additional distress and several appointments and hospital admissions that might have been avoided. However, the delays would not have altered her prognosis or treatment.

Although the Ombudsman found that the Health Board's handling of Mr A's complaint was appropriate, it failed to provide Mrs A's complete health records when requested. This caused Mr A additional time and trouble and loss of confidence in the complaint response.

It was recommended that the Health Board:

- a) Apologise to Mr A for the failings identified and make him a redress payment of £500.
- b) Review its procedures for providing records to ensure that all relevant health records relating to the patient are provided when requested.
- c) Present the findings of the investigation at an appropriate forum with the relevant medical and surgical teams with a reminder that new symptoms for patients with chronic problems should be investigated on their merit.

## Cwm Taf University Health Board - Clinical treatment in hospital Case Number: 201707407 – Report published in February 2019

Ms A complained about the care and treatment she received following the birth of her baby. She said she was discharged inappropriately and there was a failure to diagnose and treat retained products of conception ("RPOC") promptly.

The Ombudsman found Ms A's discharge and treatment of her suspected RPOC was reasonable and in line with relevant guidance, therefore these aspects of her complaint were not upheld. However, on one occasion when attending as an outpatient, Ms A was sent away although a review of her symptoms

should have taken place. While this may not have changed her management, there was a missed opportunity to diagnose her RPOC from an earlier time and to provide additional monitoring and support, therefore this element of her complaint was upheld. The Health Board was also unable to locate Ms A's records for this period of care causing additional uncertainty and distress.

The Health Board agreed to apologise to Ms A for the failings identified, and to provide redress of £500 for the distress and inconvenience caused. It also agreed to share the report with relevant staff for critical reflection. In addition, the Health Board advised a review was being undertaken into the storage and tracking of records to prevent future incidents.

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

[Case Number: 201707739 – Report published in February 2019](#)

Ms A complained about the care and treatment she received during a gynaecology appointment at a Community Hospital. She said a Consultant took a biopsy without discussing the procedure with her or seeking her consent.

The Ombudsman found the indication for the biopsy, or an explanation of its side effects, was lacking in the records, and there was sparse evidence to indicate informed consent was specifically obtained for the biopsy. The Ombudsman found there was a failure in communication and record keeping and upheld the complaint. The Health Board agreed to apologise to Ms A for the failings identified, and to provide a redress payment of £250 for the distress and inconvenience she experienced. It also agreed to share the report and hold a debrief with relevant medical staff, and to ensure they were aware of relevant guidance on consent.

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

[Case Number: 201706179 – Report published in February 2019](#)

Mrs A complained about her late husband, Mr A's, management and care during his inpatient admissions at Singleton Hospital in May and June 2016. Sadly, Mr A, who was terminally ill, died during his last admission. Mrs A was also dissatisfied with the Health Board's handling of her complaint.

The Health Board acknowledged that the nursing care Mr A received fell below the standard it would expect. The Ombudsman during the course of his investigation identified clinical, communication and administrative failings that impacted on the quality of care that Mr A received. The Ombudsman therefore upheld this part of Mrs A's complaint.

In responding to the Ombudsman's investigation, the Health Board also accepted that there had been administrative shortcomings in its handling of Mrs A's complaint, and it offered appropriate financial redress in recognition of this. Again, the Ombudsman upheld this aspect of Mrs A's complaint. The Ombudsman recommended that the Health Board apologise to Mrs A for the failings identified and evidence the action it had taken and intended to take as a result of Mrs A's complaint.

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

[Case Number: 201707989 – Report published in February 2019](#)

Mrs A complained about the treatment received by her mother from Aneurin Bevan University Health Board ("the Health Board") between 11 December 2017 and 3 January 2018. She complained that:

- a) The fluid on her mother's lungs was not adequately diagnosed, monitored or treated.
- b) The family should have been informed about her mother's choking incident on the ward on 20 December.
- c) Her mother's transfer on 3 January was not appropriate.
- d) Her mother's pneumonia was not diagnosed prior to her transfer on 3 January.
- e) Family and friends were deprived of the opportunity to say goodbye to her mother due to lack of communication from the hospital.

The Ombudsman's investigation found that the Health Board missed an opportunity to commence antibiotics earlier and whilst this may not have changed the ultimate outcome, this left Mrs A with an uncertainty about her mother's treatment. The Ombudsman therefore upheld this part of the complaint. The investigation found however that the choking incident was responded to appropriately with no action required from the family and that Mrs A's mother appeared clinically well enough for transfer. The Ombudsman was not persuaded that, without the benefit of hindsight, the Health Board could have reasonably known how quickly Mrs A's mother would deteriorate. These aspects of the complaint were therefore not upheld.

The Ombudsman recommended that the Health Board apologise to Mrs A for the failings identified in the report and review the way in which chest examinations are undertaken and recorded for patients who have experienced a choking incident.

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

[Case Number: 201800071– Report published in February 2019](#)

Ms A complained about the care and treatment received by her daughter, Miss B following her admission to hospital on 2 March 2017. In particular, Ms A complained that:

- a) Miss B was not given appropriate pain relief after being admitted to hospital.
- b) Hygiene levels in Miss B's cubicle were unacceptable as used bedpans were left to gather in the patient toilet.
- c) The accumulation of used bedpans contributed to Miss B's father, Mr C, contracting E.coli 0157.
- d) Miss B did not receive sufficient monitoring by nursing staff.
- e) There was a delay in diagnosing and treating Miss B's E.coli 0157 and Haemolytic Uremic Syndrome (HUS).

The Ombudsman's investigation found that Miss B's pain was not sufficiently managed or monitored following her admission and that hygiene levels in her cubicle were inadequate and presented a significant infection risk. This may have contributed to other family members becoming unwell. The Ombudsman therefore upheld these parts of Ms A's complaint.

The investigation also found that whilst some of Miss B's observations were monitored adequately, her fluid loss records were inconsistent and inadequate. The Ombudsman therefore upheld this aspect of Ms A's complaint.

The Ombudsman found that Miss B was regularly monitored for changes to her kidney function and transferred to an appropriate specialist as soon as problems were detected. He therefore did not uphold the complaint that there was a delay in diagnosis and treatment.

The Ombudsman recommended that the Health Board apologise to Ms A and make a redress payment of £1,000 in recognition of the distress caused by the failings identified. He also recommended that the Health Board remind all staff of the importance of adequate infection control, accurate record keeping including in cases of fluid loss and to review its policy and procedures for paediatric pain management.

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

[Case Number: 201708070 – Report published in March 2019](#)

Ms X complained about the care and treatment she received from the Midwifery Team based within Cardiff and Vale University Health Board ("the Health Board"). Specifically, Ms X said that information about her included within a Multi-Agency Referral Form ("MARF"), completed by two Midwives was inaccurate and portrayed her as being unstable, unsafe and un-cooperative. Additionally, Ms X complained that she was not

informed that the referral had been made and that in consequence of the inaccurate portrayal she was denied the opportunity of choosing where to give birth as her unborn child was placed on the Child Protection Register.

The Ombudsman concluded that there were a number of factual inaccuracies in the referral form and that assumptions had been made by the Midwives which were not fully supported by the information available to them. He concluded that as a result Ms X had been portrayed in an unfavourable manner. He was satisfied also that a decision not to inform Ms X that a referral had been made was not reasonable.

However, the Ombudsman was not able to conclude, on balance, at that in direct consequence of the failings identified that Ms X's choices relating to the birth of her child were impacted as suggested by Ms X. The Ombudsman considered that there were other factors which may also have impacted on her decision and her ability to have the birth of her choice. He recognised however that the failings which were identified were capable of casting doubt on the events which unfolded and therefore gave rise to considerable uncertainty for Ms X.

Ms X's complaints were partly upheld. The Health Board agreed to:

- d) Apologise to Ms X for the failings identified
- e) Pay £750 to Ms X in recognition of the uncertainty caused
- f) Place a copy of the report and apology within Ms X patient records
- g) Discuss findings of the report with the staff involved and consider whether referral to the NMC is required
- h) Refer the case to its Quality Safety and Experience Committee and Equalities and Human Rights Officer
- i) Consider the case as a learning exercise

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

[Case Number: 201703022 – Report published in March 2019](#)

Mrs A complained that there was a failure to provide adequate care and treatment following surgery in 2011 to repair a posterior prolapse. Mrs A also complained that there was a failure to treat her prolapse and refer her for appropriate surgery and provide her with necessary equipment to aid her recovery. Finally, Mrs A complained about poor communication on the part of the clinicians and the Health Board's failure to adequately respond to her complaint.

The complaint was partly upheld. The investigation found evidence of poor communication on the part of the clinicians which had a significant impact on Mrs A's understanding of her health concerns and the treatment that she was receiving. This detrimentally impacted the relationship between Mrs A and her clinicians. The investigation found that there were delays in follow-up care and the provision of medical equipment to aid Mrs A's recovery. Finally the investigation found failings in the Health Board's complaint handling.

It was recommended that the Health Board apologise to Mrs A for the failings identified in the report and remind relevant clinicians of the need for clear communication with patients and to ensure that patients understand the ERAS approach. Additionally, it was recommended that the Health Board remind clinicians to inform patients that test results would be available from the GP. It was also recommended that the investigation staff are reminded of the Health Board's obligations under the Equality Act 2010. Finally, it was recommended that the Health Board consider facilitating a further appointment so that Mrs A was given the opportunity to discuss her ongoing treatment options.

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

[Case Number: 201704872 – Report published in March 2019](#)

Mr A complained about the care and treatment commissioned by Powys Teaching Health Board ("the Health

Board") for his daughter, Ms B, at three separate mental health facilities between June 2015 and 22 March 2017. Mr A also complained about the nature of Ms B's transfer between two of the facilities.

The Investigation found that access to medical treatment was delayed and that there were failings to follow up concerns about adult protection. The investigation also found evidence of poor and inaccurate communication between the Health Board and Mr A. The complaint was partly upheld.

It was recommended that the Health Board apologise and pay Ms B £1000 in recognition of the identified failings. It was also recommended that the Health Board discuss the content of this report with the relevant Health Board officers, and identify what lessons could be learned. Finally it was recommended that the Health Board share this report with the identified providers and review its process for monitoring commissioned services for adults.

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

[Case Number: 201708060 – Report published in March 2019](#)

Mr and Mrs X complained about the maternity care received at Ysbyty Gwynedd. They said that there was a failure to follow the agreed birth plan which restricted consent to the administration of their son's dose of vitamin K to orally instead of an injection into the muscle. They also said that there was a failure to follow the Health Board's Group B Streptococcus Disease ("Strep B") protocol and that Mrs X was prescribed antibiotic medication which affected her ability to breast feed. Mr and Mrs X complained that there was a failure to provide adequate midwifery/nursing care for Mrs X and Baby Y, and that Mrs X was not provided breast feeding support to help maintain the production of her breast milk. Finally, they complained that there was a failure to appropriately address their complaint.

The investigation found that the Health Board accepted that, contrary to Mrs X's birth plan and expressed wishes, Baby Y was administered an intramuscular injection of vitamin K. The investigation also found that the Health Board's Strep B protocol had been followed and that the antibiotics prescribed for Mrs X had been necessary and appropriate. Furthermore, the investigation found that the nursing/midwifery care, including breast feeding support, had been adequate. Finally, the investigation found that the Health Board had failed to appropriately address Mr and Mrs X's complaint. The complaint was partly upheld.

It was recommended that in addition to the training the Health Board had undertaken in response to this complaint, it also apologise to Mr and Mrs X for the failings identified, and pay them £250 in recognition of the poor complaint handling. It was also recommended that the Health Board remind officers of the need to keep complainants updated on the progress and outcomes of investigations, particularly on the spot investigations.

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

[Case Number: 201801446 – Report published in March 2019](#)

Mr A complained that there had been an unnecessary delay for surgery, despite being placed on the urgent list. Mr A also complained that there had been a failure to provide appropriate pain relief while he waited for surgery. Mr A said that following surgery, he was discharged from hospital with no follow up appointment. Finally, Mr A complained that there had been a failure to appropriately respond to his complaint in accordance with the Regulations.

The investigation found that there has been a failure to inform Mr A that his surgery was to be significantly delayed. However, it was noted that in the interim, Mr A's pain was managed in accordance with national guidelines. The investigation also found that Mr A had been given incorrect information relating to discharge and a follow-up appointment which caused him unnecessary worry. Finally the investigation found that, although the Health Board had responded to Mr A's complaint in accordance with the Regulations, it had missed an opportunity to resolve the matter at an earlier stage. The complaint was partly upheld.

It was recommended that the Health Board apologise to Mr A and pay him £500 in recognition of the failings identified. It was also recommended that the report was shared with the Booking Team and that the Health Board undertake a review of its process for keeping patients updated when treatment is delayed.

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

[Case Number: 201801484 – Report published in March 2019](#)

Mrs X complained that there was a failure to provide her with adequate breastfeeding support following the birth of her son, Baby R. Mrs X also complained that it took six weeks to diagnose Baby R's posterior tongue-tie and inability to breastfeed. Finally, Mrs X complained that the Health Board had failed to adequately respond to her complaint.

The investigation found that, following her discharge from hospital, Mrs X received breastfeeding support from the Community Midwife and the Health Visitor. The investigation also found that opportunities to refer Baby R to the Breastfeeding Specialist at an earlier time had been missed. Finally, the investigation found that the Health Board had failed to fully address Mrs X's concerns and provide an explanation of the failings it had identified. The complaint was partly upheld.

It was recommended that the Health Board apologise to Mrs X and pay her £250 in recognition of the identified failings. It was also recommended that the Health Board ensures that its annual training on breastfeeding includes information on the different types and signs of tongue-tie, and reviews its breastfeeding assessment tool/checklist and examination checklist to ensure that babies who are failing to thrive are examined for tongue-tie.

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

[Case Number: 201705512 – Report published in March 2019](#)

Mr B complained to the Ombudsman about failings in the care and treatment that his late mother, Mrs M, received during her admissions to Singleton Hospital in October 2016 and January 2017. Mr B complained that:

- (a) Clinicians failed to adequately manage Mrs M's confusion and pain
- (b) There were occasions during her admissions when her dignity was compromised
- (c) The family only learned of Mrs M's diagnosis of terminal ovarian cancer from a member of a Palliative Care Team who called (unexpectedly) at the family home after her discharge
- (d) Following an allegation that a nurse had assaulted Mrs M, a POVA investigation was conducted by the police and the Health Board. Whilst the allegation was not upheld, the Health Board failed to inform the family about the outcome of the investigation.

The Ombudsman upheld complaints 1, 3 and 4 and partially upheld complaint 2.

The Ombudsman recommended that the Health Board provides Mr B with a fulsome written apology for the clinical and communication failings the investigation identified and, in recognition of the distress the family experienced as a result of the identified failings, makes a payment to him of £500.

The Ombudsman also recommended that the report is shared with the clinicians involved in Mrs M's care and that they are reminded of the importance of:

- (a) Adhering to the Health Board's Discharge Policy
- (b) Implementing the Dignity and Care of Older People Policy
- (c) Referring patients appropriately to the Hospital's Psychiatric Liaison Team
- (d) Maintaining detailed records of the behaviour and problems of patients suffering from confusion and disorientation



- (e) Adhering to the provisions of the All Wales POVA Policy in respect of providing feedback to family members and referrers.

The Health Board agreed to implement these recommendations.

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

Case Number: 201706226 – Report published in March 2019

Mr A complained that Cardiff and Vale University Health Board (“the Health Board”) did not manage his shoulder surgery or his post-operative care appropriately. He raised specific concerns about consent, surgical performance, the diagnosis of rotator cuff tendon damage and the provision of physiotherapy. He also complained about the Health Board’s handling of his related complaints. His dissatisfaction concerned its responses to his initial verbal complaint and his subsequent written complaint.

The Ombudsman did not uphold the clinical care aspects of Mr A’s complaint. Nor did he uphold that part of Mr A’s complaint which concerned the Health Board’s response to his verbal complaint. He found that the Health Board’s response to Mr A’s written complaint had been unreasonably delayed and that the Health Board had failed to update him effectively. He upheld the written complaint element of Mr A’s complaint as a result. He asked the Health Board to write to Mr A to apologise for these complaint handling failings and to explain why its Management Team had not sent him a further written response to his concerns. The Health Board agreed to implement these recommendations.

## Aneurin Bevan University Health Board – Other

Case Number: 201707782 – Report published in March 2019

Mrs T complained that her son, Child K, was denied the drug Sirolimus by Aneurin Bevan University Health Board (“the Health Board”) for a period of seven months, which exacerbated his PIK3CA related overgrowth of the right lower limb (sometimes referred to as gigantism). Mrs T also complained about the delay in her son being seen by the Child and Adolescent Mental Health Services (“CAMHS”) team and by a child psychologist.

The Ombudsman’s investigation found that it was reasonable of Child K’s GP and the Health Board to refuse to prescribe Sirolimus as it was usually used to prevent a kidney transplant from being rejected. As the drug was being used ‘off label’ (not for its intended use) during a trial, and the Health Board had no shared-care arrangements in place, the Ombudsman could not criticise the Health Board despite Child K benefitting from using the drug. The Ombudsman noted, however, that there did not appear to have been a continuity of care plan put in place by either the hospital overseeing the trial, or a specialist hospital who oversaw Child K’s care in readiness for when the trial ended. The Ombudsman also noted that a full explanation for not prescribing the drug was not given to Mrs T in a timely manner.

In relation to the delays incurred by Mrs T and Child K in being seen by the CAMHS team and by a child psychologist, the Ombudsman concluded that whilst they were unfortunate, they were not excessive, nor could they be attributed solely to the Health Board. Most of the delays were incurred prior to input from the Health Board and were due to either referrals not meeting set criteria or having been sent to the wrong hospital.

## Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201800493 – Report published in March 2019

On 24 June 2017, Mr X (then aged 74 years) was admitted to the Prince Charles Hospital with episodes of violent vomiting. Mr X was discharged on 28 September and sadly died on 18 October. Mrs X complained that Mr X’s cancer should have been diagnosed earlier than 13 September. Mrs X also complained that an earlier diagnosis would have led to a different treatment which might have enhanced Mr X’s quality of life.

The Ombudsman found that subtle changes to Mr X’s 28 June CT and 7 July MRI scans should have been identified as being suggestive of pancreatic cancer and there was a delay in the diagnosis. He found that

an earlier diagnosis would have led to earlier palliative treatment being offered that could have had a beneficial effect on Mr X's quality of life. The Ombudsman upheld the complaint. The Health Board agreed to implement the Ombudsman's recommendation to inform the the local and regional Multi Disciplinary Teams of the outcome of this investigation.

## Cardiff and Vale University Health Board - Clinical treatment outside hospital Case Number: 201801428 – Report published in March 2019

Mr C complained that between November 2014 and October 2017 the Community Mental Health Team ("CMHT") at Cardiff and Vale University Health Board ("the Health Board") did not provide him with a reasonable standard of service. He said that inconsistencies in care provision, poor communication and a failure to allocate his care to a CPN care coordinator led to the deterioration in his mental health, which ultimately resulted in his detention and admission to hospital under Section 2 of the Mental Health Act 1983.

The Ombudsman found that there is no automatic entitlement to request a particular speciality to fulfil the care coordinator's role and that the staff allocated and involved in Mr C's care were appropriate to address his particular needs. He found that there were some failures in record keeping, including a prolonged failure to provide Mr C with a written care plan, but that overall Mr C received adequate and appropriate support throughout the period and there was no evidence to suggest his care should have been any different if it had been written up. The Ombudsman did not uphold these elements of the complaint.

However, the Ombudsman acknowledged that Mr C was frustrated with the CMHT's continued refusal to allocate a CPN to be his care coordinator or to provide him with a Care Plan. Mr C's repeated requests for these things should not have been overlooked. In addition, when Mr C requested transfer of his care to an alternative CMHT, there was no evidence to demonstrate that Mr C was kept appropriately informed throughout the process despite delays protracting the decision. The Ombudsman upheld these elements of the complaint.

The Ombudsman invited the Health Board to review its systems for record keeping, and to remind its staff at the CMHT of the importance of ensuring full and meaningful record keeping.

He also recommended that, within one month of the date of the Ombudsman's report, the Health Board should:

- (a) Apologise to Mr C for the failings identified
- (b) Remind its CMHT staff of the importance of ensuring full and meaningful communication with its patients and service users, to explain its decisions and ensure that they are kept appropriately informed about their care and treatment
- (c) Consider the referral process when requests are made to transfer patients between CMHTs, to identify any shortcomings that might cause undue delay, and determine an appropriate action plan to address them and prevent a recurrence in future.

## Welsh Ambulance Services NHS Trust – Ambulance Services Case Number: 201800772 – Report published in March 2019

Mrs Y complained that the Welsh Ambulance Services NHS Trust ("WAST") did not respond appropriately to emergency calls it received in February and August 2017 and did not convey her late mother, Mrs X, to hospital within a reasonable timeframe. Mrs Y also complained that the the delay experienced in August 2017 meant that Mrs X missed the treatment window for her stroke. Sadly, Mrs X died a few days later.

The Ombudsman found that there were no failings in relation to the calls in February. In relation to the calls in August, WAST acknowledged that one of these had been incorrectly categorised, leading to a delay of 13 minutes in an ambulance being dispatched to Mrs X. The Ombudsman upheld this part of the complaint to

the extent that the delay will have contributed to the worry and distress experienced by Mrs X and her family.

However, the Ombudsman did not uphold the complaint that the delay adversely affected Mrs X's treatment as, sadly, even if the ambulance was dispatched when it should have been, Mrs X would still have arrived at the hospital outside the treatment window.

## Hywel Dda University Health Board – Clinical treatment in hospital

Case Number: 201800368 – Report published in March 2019

Mrs A complained about Hywel Dda University Health Board's ("the Health Board") surgical management of her eye condition which she said left her with ongoing pain. Mrs A thought that something had gone wrong during her surgery and that afterward, her stitches were left in place for too long causing complications. Mrs A also said that nursing staff failed to provide her with appropriate care after her surgery, and that the Health Board did not consider her complaint properly.

The Ombudsman found that nursing staff failed to address Mrs A's pain and discomfort after her surgery. The investigation also found that Mrs A's ongoing symptoms were recognised complications of her surgery and did not indicate that something had gone wrong during the procedure itself. However, the risks and complications of the surgery were not properly discussed with Mrs A when obtaining her consent.

Furthermore, shortcomings in the Health Board's record keeping meant that the Ombudsman could not assure Mrs A that the standard of her surgery and post-operative care was reasonable. The Ombudsman was also critical of the Health Board's investigation of Mrs A's complaint which was not robust.

The Health Board agreed to apologise to Mrs A and pay her £875 in recognition of its poor response to her complaint and the uncertainty around her care caused by the poor record keeping. The Ombudsman's findings were also to be shared with its Surgical and Nursing Teams.

## Abertawe Bro Morgannwg – Clinical treatment in hospital

Case Number: 201706613– Report published in March 2019

Mr A complained about the care and treatment his late wife, Mrs A, received during her final admission to Morriston Hospital ("the Hospital") between 27 December 2016 and 8 January 2017, including the medication prescribed and poor record keeping. Additionally, he was dissatisfied with the Health Board's handling of his complaint.

Given there were issues around medication administration and possible harm the Health Board offered to re-engage with Mr A via its Putting Things Right process which Mr A accepted. The Ombudsman's findings therefore did not relate to this aspect of Mr A's complaint. The Ombudsman's investigation found that overall the medical care Mrs A received was appropriate and acceptable and did not uphold these aspects of Mr A's complaint.

The investigation found, that apart from the management of Mrs A's skin tear by nursing staff broadly the documentation in Mrs A's medical records was legible and record keeping was adequate. The Ombudsman was disappointed that in responding to Mr A's initial complaint the Health Board did not recognise the shortcomings around its medication administration and to this limited extent only Mr A's complaint was upheld. The Health Board was asked to apologise to Mr A for the failings identified by the investigation and in recognition of inadequacies in complaint handling make a payment to Mr A of £250.

## Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Number: 201800190 – Report published in March 2019

Mrs A complained about the care and treatment her mother, Mrs M, received during her inpatient admission at Ysbyty Ystrad Fawr. Mrs A's concerns included the following: the failure to provide adequate pain relief when her mother's pessary was removed and her mother not being given ulcer relieving medication prescribed by the Gynaecologist. Mrs A also complained about a delay in carrying out falls risk

assessments following her mother's admission.

The Ombudsman's investigation found aspects of the care provided to Mrs A's mother was reasonable and did not uphold those parts of Mrs A's complaint. However, he did identify that Mrs M was not adequately assessed on admission and that there was a delay in providing bedrails and carrying out a risk assessment after each fall. He also found that Mrs M was not administered the medication for her ulceration. These aspects of Mrs A's complaint were upheld.

Amongst the recommendations the Ombudsman made was that the Health Board should apologise to Mrs A for the failings identified and ensure that staff were provided with training in relation to falls prevention and appropriate use of bedrails. The Health Board was also asked to remind its clinicians about their professional obligations around record-keeping.

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

[Case Number: 201800660 – Report published in March 2019](#)

Mrs A complained about the post-operative medical and nursing care that her late mother, Mrs M, received following hip surgery in March 2016. Mrs A said that post-operatively her mother developed an acute deterioration of her kidney function (acute kidney injury "AKI") and there was a delay in her receiving treatment. Mrs A said that her mother died within 48 hours of surgery following a cardiac arrest. Mrs A also complained about the Health Board's delay in dealing with her complaint.

The Ombudsman's investigation found that despite repeated blood tests being carried out which indicated that Mrs M was dehydrated the results were not acted upon. As a result, there were missed opportunities for earlier intervention regarding Mrs M's AKI and a delay in diagnosing and treating her. The investigation also found that when Mrs M's condition deteriorated nursing staff failed to escalate her care as required for clinical medical review. The Ombudsman concluded that in view of the shortcomings he could not rule out the possibility that had clinicians intervened sooner the outcome for Mrs M might have been different.

The Ombudsman found that the Health Board's complaint handling and review of Mrs M's care lacked sufficient depth and rigour. The Ombudsman upheld Mrs A's complaint and the recommendations included the Health Board apologising to Mrs A and her family for the failings identified by the Ombudsman's investigation. Additionally, he recommended that the relevant clinicians undergo further training, with particular reference to national and professional guidelines, on the recognition of sepsis and the risk of AKI and the importance of escalating a patient's care in accordance the relevant clinical tool.

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

[Case Number: 201706689 – Report published in March 2019](#)

In January 2017, Mrs J was admitted to a hospital run by Cardiff and Vale University Health Board ("the Health Board") for surgery to improve her pelvic floor problems. Mrs J complained that the consent process was inadequate, that the surgery was not undertaken to an acceptable standard and that, post-operatively, there were failings in her care and communication with her about her clinical condition.

Mrs J also said that following a further hospital admission later that year, she had been discharged with incorrect paperwork and that a relevant follow-up appointment had not been made. Finally, Mrs J complained about how the Health Board had handled her complaint.

The Ombudsman's investigation identified concerns about the consent process, and he upheld this complaint; he found that the surgery itself had been undertaken with reasonable skill and care and he did not uphold this complaint. The Ombudsman concluded that the care and treatment provided by clinicians post-operatively was of poor quality and that communication with Mrs J about her clinical condition was inappropriate. These complaints were also upheld.

Considering Mrs J's additional hospital admission in 2017, the Ombudsman agreed that Mrs J had been discharged with the incorrect paperwork and upheld this complaint. The Ombudsman did not uphold Mrs J's complaint about a follow-up appointment being made. Finally, the Ombudsman partly upheld Mrs J's concerns about the Health Board's handling of her complaint.

The Ombudsman recommended that the Health Board apologised and provided Mrs J with a redress payment of £2250 which it agreed to.

The Health Board also agreed with the Ombudsman's recommendation to provide evidence of the actions taken by its Governance and Safety Teams in respect of reminding clinicians about the official guidelines in relation to consent and that the clinicians involved in this case would discuss the Ombudsman's findings at their annual reviews.

## [Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) Case Number: 201802989 – Report published in March 2019

Mrs A complained that the Emergency Department ("the ED") of Morriston Hospital did not carry out an X-ray on 18 January 2018 when she attended after fainting and collapsing at home. A GP referral to the fracture clinic for an X-ray led to a vertebral fracture being diagnosed in April. In the intervening period, Mrs A said she had made repeated visits to her GP because of the pain.

The Ombudsman's investigation found shortcomings in Mrs A's pain management at the ED as well as failings in her clinical assessment which meant that her lower back was not examined, despite her early reports of pain in that region. Administratively, he also identified inadequacies around record keeping. Whilst the Ombudsman could not say definitively that an X-ray would have been warranted in Mrs A's case, neither could he rule it out, given Mrs A's clinical presentation. Given the clinical and administrative failings identified he upheld Mrs A's complaint.

The Health Board having identified shortcomings around complaint handling offered Mrs A a financial redress payment in recognition of this.

The Health Board accepted the Ombudsman's recommendations which included apologising to Mrs A for the failings identified and disseminating the report to the key clinicians involved to assist with reflective learning.

## **Not upheld**

### [Aneurin Bevan University Health Board - Clinical treatment in hospital](#) Case Number: 201707931– Report issued in January 2019

Mr A complained about the care and treatment he received from the Health Board. Specifically, Mr A complained that the decision to undertake keyhole surgery was inappropriate given the increased size of his hernias, that he was incorrectly diagnosed with a seroma (a collection of sterile fluid under the skin), and that there had been a failure to undertake a review following his surgery, or provide appropriate after care advice. Finally, Mr A complained that, having been referred by his GP for further investigations into continued pain and discomfort, he was treated as a new referral rather than as requiring ongoing treatment.

The investigation found that the clinical care Mr A received had been reasonable, and that there had been no clinical indication that the further investigations should be prioritised. The complaint was not upheld.

### [Aneurin Bevan University Health Board - Appointments/admissions/discharge and transfer procedures](#) Case Number: 201706646– Report issued in January 2019

Mr A complained that his wife, Mrs A, was inappropriately discharged from the Orthopaedic Department, to the care of the Pain Management Team at Hospital 1.

The complaint was not upheld. The Ombudsman concluded that, overall, the care and treatment Mrs A had received was reasonable, and that she had not been inappropriately discharged.

## [Pendre Surgery - Clinical treatment outside hospital](#)

[Case Number: 201800773 – Report issued in January 2019](#)

Mrs Y complained about the care and treatment that was provided to her late mother (Mrs X), by the GPs based within the Surgery. Mrs Y complained that appropriate investigations, including hospital referrals, were not undertaken following Mrs X reporting numbness in her cheek and pain in her neck, between June and July 2017, and spontaneous bruising to her arms between May and August 2017. In addition, Mrs Y complained that appropriate investigations, including hospital referrals, were not undertaken following receipt of Mrs X's blood test results on 16 May 2017. Mrs Y questioned whether Mrs X's prescribed medication regime should have been altered.

The investigation found that the investigations undertaken and arranged by the respective GPs in relation to the numbness in Mrs X's cheek, the pain in her neck and the spontaneous bruising to her arms was reasonable. In addition, the management of the symptoms was within the bounds of clinical practice.

Furthermore, the investigation found that the blood tests undertaken were reported on correctly and the GP exercised a degree of caution by making a referral to the Consultant Haematologist. It was reasonable clinical practice for the GP to follow the advice of the Consultant Haematologist who advised that Mrs X should continue with her prescribed medication.

The investigation found no basis on which to criticise the actions of the Surgery and Mrs Y's complaint was not upheld.

## [St David's Clinic - Clinical treatment outside hospital](#)

[Case Number: 201801062– Report issued in January 2019](#)

Mr X complained about the care and treatment that he received from the GPs based within a GP Practice in the area of Aneurin Bevan University Health Board. In particular, he complained that his observed and reported symptoms between March and May 2017, should have led clinicians to reasonably suspect a diagnosis of cancer and make the necessary onward referrals for further investigation. In addition, Mr X complained that his clinical notes did not accurately reflect his measured body weight and the concerns that he held regarding his weight loss between March and July 2017.

The investigation found that the possible diagnoses considered by the respective GPs at each consultation between March and May were clinically reasonable. The earliest that cancer could have been considered was on 25 May and appropriate action was taken on 26 May when Mr X was referred for an urgent CT scan. The referral was appropriately marked 'urgent-cancer'. The investigation found no basis on which to criticise the actions of the GPs and the complaint was not upheld.

In addition, the investigation found that the clinical notes did not support Mr X's reported weight loss and his account of discussions held with the GPs and Practice Nurse were at odds with the contemporaneous clinical records. In the absence of any other evidence, the two accounts could not be reconciled in a way that would allow the Ombudsman to make a definitive finding.

## [The Robert Street Practice - Clinical treatment outside hospital](#)

[Case Number: 201801913 – Report issued in January 2019](#)

Mrs X complained that the care and treatment provided to her mother, Mrs Y, by GPs at the Practice at five appointments prior to her death, was inadequate. Mrs X complained that the GPs failed to recognise Mrs Y's cardiac-related symptoms and that if they had, she could have been referred for further investigations and treatment, which may have prevented her death.

The Ombudsman found that the treatment provided by the GPs at the Practice was clinically reasonable

and that there had been no evidence to admit Mrs Y to hospital for treatment or indication that she would develop a fatal cardiac condition. The Ombudsman was also satisfied that, even if a referral to a cardiologist had been made, this would have been for a non-urgent consultation and therefore, it was highly unlikely that Mrs Y would have seen a cardiologist prior to her death. The Ombudsman did not uphold the complaint.

## Welsh Ambulance Services NHS Trust - Clinical treatment outside hospital

Case Number: 201707727 – Report issued in January 2019

Mr A complained about the care provided to his late mother, Mrs B, by St John Cymru – Wales (“SJCW”) who provided Mrs B with transport services on behalf of Welsh Ambulance Services NHS Trust (“WAST”). The investigation considered whether the decision by WAST to send SJCW to convey Mrs B to hospital was appropriate, the way SJCW managed the transfer, and whether there were any failings which resulted in Mrs B fracturing her leg, and the investigation of Mr A’s concerns by both organisations.

The Ombudsman was satisfied that the decision by WAST to send SJCW was appropriate and one it was entitled to take. He did not uphold this complaint.

The Ombudsman was unable to reach a view on what most likely happened when SJCW transferred Mrs B and whether this caused a fracture, and there is a dispute about whether Mrs A was ‘dropped’ or lowered to the floor in a controlled manner. However, he found that the failure to document the fall or report it to the hospital, regardless of the mechanics of how it happened, was a service failure. He upheld the complaint to the extent there was a failure to document the fall which may have delayed precautionary X-rays and earlier diagnosis and treatment of Mrs B’s fracture. He made a number of recommendations to SJCW, including an apology.

The Ombudsman found that whilst Mr A was concerned that neither WAST nor SJCW visited the home to examine the layout of the room or interviewed him as a significant witness, neither body acted outside the expectations of the relevant complaint handling regulations in this regard in investigating Mr A’s complaint. He did not uphold this complaint.

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

Case Number: 201800408 – Report issued in January 2019

Miss A complained about the care and treatment received by her mother, Mrs B, from Cardiff and Vale University Health Board (“the Health Board”). In particular, she complained that there was an unreasonable delay in the time it took for her mother to be prescribed antibiotics, that her mother was dehydrated due to being given inadequate fluids while she was in hospital and intravenous (IV) fluids should have been prescribed sooner, and that her mother was suffering from oral thrush which was not treated in a timely manner.

The investigation found that Mrs B was prescribed antibiotics in an appropriate and timely manner and that IV fluids were provided in accordance with her care plan when it was no longer safe for her to drink. The investigation found that although there was a slight delay in commencing treatment for Mrs B’s oral thrush, the delay did not have any significantly adverse clinical impact. The Ombudsman therefore did **not uphold** Miss A’s complaint.

## Killay Surgery - Clinical treatment outside hospital

Case Number: 201801444 – Report published in February 2019

Ms A complained about the care she received from her GP Surgery (“the Surgery”). Specifically, Ms A complained that the staff seen at the Surgery failed to refer her for a scan when she attended on two occasions in August 2017 with symptoms of an early miscarriage.

Having considered the relevant NICE guidance, Ms A’s patient records, the evidence of both Ms A and the Surgery and with the benefit of advice from one of his clinical advisers, the Ombudsman was satisfied on

balance that the management of Ms A's care was appropriate on each occasion.

The symptoms reported by Ms A during each appointment did not provide an indication for referral to the early pregnancy assessment service for a scan under the relevant guidance.

Ms A's complaint was not upheld.

## [Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201705982– Report published in February 2019](#)

Ms T complained to the Ombudsman that the failure of obstetric physicians and midwives at the University Hospital of Wales to appropriately manage her condition of Major Placenta Praevia, led to the demise and subsequent stillbirth of her baby. Ms T complained that clinicians:

- Failed to promptly deliver her baby via emergency Caesarean Section
- Failed to appropriately respond to or record the onset of acute abdominal pain that she reported to a midwife on the evening before her baby died.

The Ombudsman did not uphold Ms T's complaint. He determined that her condition was managed in accordance with appropriate clinical guidance and that the stillbirth of Ms T's baby was unexplained and not linked to any failure of care.

The Ombudsman was unable to find any evidence within the detailed records made by midwives that supported Ms T's assertion that she reported being in pain on the evening before her baby died. In view of this, he was unable to reach a finding on this element of Ms T's complaint.

The Ombudsman stressed that his decision did not reflect any lack of sympathy with the tragic and distressing loss that Ms T suffered.

## [Cwm Taf University Health Board - Clinical treatment outside hospital](#) [Case Number: 201800584– Report published in February 2019](#)

Mr X complained that, while he was a patient at the Mental Health Unit, he was inappropriately refused medication, refused planned activities without a reasonable explanation, and there had been a failure to appropriately manage his discharge from the Mental Health Unit.

The investigation found that, whilst Mr X was clearly very unhappy with his care at the Mental Health Unit, there was no evidence available to support his concerns.

## [Cathays Surgery - Clinical treatment outside hospital](#) [Case Number: 201800375– Report published in February 2019](#)

Mr X complained about the treatment that he received at a GP Practice ("the Practice") between March and November 2017. Mr X complained that he should have been diagnosed with Crohn's disease. In August, while in the USA, Mr X was diagnosed with Crohn's disease and administered mesalazine (a drug to treat Inflammatory Bowel Disease). Mr X complained that on his return, the Practice refused to administer the USA treatment and he was referred to the gastroenterology service. In December, in a private consultation Mr X was diagnosed with Crohn's disease.

The Ombudsman found that Mr X's treatment and referral to establish a diagnosis were reasonable, and the USA documents had not specified the type of colitis or a regime for medication. He found that the delay in diagnosis was because the GPs' referrals were not acted on by the Health Board. The Ombudsman did not uphold the complaint.

## [Keir Hardie Health Park - Clinical treatment outside hospital](#) [Case Number: 201801493– Report published in February 2019](#)



Miss A complained that her GP Practice failed to act on her symptoms of chest, back and armpit pain from early 2017. Miss A was concerned that there was consequently a delay in her being diagnosed with breast cancer.

The Ombudsman found that the symptoms Miss A had reported would not reasonably have caused the GPs who saw her to consider that she had breast cancer. He did not uphold the complaint.

## Westway Surgery - Clinical treatment outside hospital

Case Number: 201800678 – Report published in February 2019

Mrs B complained that a GP at the Practice failed to ensure her mother ("Mrs C"), who was resident at a Care Home, received a flu jab in November **2017** and that the failure to provide a flu jab may have contributed towards Mrs C's death from pneumonia in December.

The Ombudsman found that it was appropriate for the GP to rely on information provided by the Care Home (that consent had not been provided for the flu jab). He also found that there was no evidence that Mrs C had flu either before or during her pneumonia and therefore not having the flu vaccine did not contribute to her death. He did not uphold Mrs B's complaints.

## Fairfield Surgery - Appointments/admissions/discharge and transfer procedures

Case Number: 201800729 – Report published in February 2019

Mrs A complained that a GP Practice in the area of Hywel Dda University Health Board ("the Practice") failed to refer her for investigations regarding the lump on her tongue in a timely and appropriate manner. She said that the Practice's failure to make an appropriate referral resulted in a delay in her diagnosis of cancer. She also complained that she would not have required two surgical procedures to her tongue if she had been referred in a timely manner.

The Ombudsman found that the Practice referred Mrs A for further investigation in a timely and appropriate manner and she was seen quickly by the relevant specialists. The Ombudsman also found that Mrs A's second surgical procedure was necessary as a precaution. He therefore did not uphold Mrs A's complaint about the care and treatment she received from the Practice.

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

Case Number: 201801121 – Report published in February 2019

Mr A complained about the care and treatment received by his father, Mr B, following his admission hospital on 5 June 2017. In particular he complained about the care and management of his father's ischaemic leg including the timeliness of its amputation and that his father was incorrectly diagnosed with cancer.

The Ombudsman's investigation found that other clinical concerns, including the need for urgent bowel surgery, sepsis, kidney failure, lung cancer and pneumonia, superseded the treatment of Mr B's ischaemic leg. The investigation found no evidence that amputation of Mr B's leg any sooner would have improved his condition or altered the ultimate outcome. The Ombudsman therefore did **not uphold** this aspect of the complaint.

The investigation found that Mr B's diagnosis of cancer was supported by clinical test results and confirmed during the post mortem examination. Mr A's complaint that his father was incorrectly diagnosed with cancer was therefore **not upheld**.

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

Case Number: 201801879 – Report published in March 2019

Mrs A complained about the delay she experienced waiting for treatment for her knee injury. The investigation found that, whilst the wait for treatment had exceeded the Welsh Government referral to treatment guideline of 36 weeks, there was no evidence that Mrs A's surgery should have been triaged as urgent, or that she experienced any greater delay than other routine patients waiting for similar

surgery. The complaint was not upheld.

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

[Case Number: 201802013 – Report published in March 2019](#)

Mr A complained about unreasonable delays by the Health Board in providing de-sensitisation therapy for his symptoms of needle phobia to allow his planned hip replacement surgery to go ahead.

The Ombudsman found that the Health Board had appropriately signposted Mr A to locally available services in March 2016, and that its pain management programme included provision of de-sensitisation therapy work. The complaint was not upheld.

## [Deeside Medical Centre - Clinical treatment outside hospital](#)

[Case Number: 201801696 – Report published in March 2019](#)

Ms A complained about the care and treatment she received from one of the GPs (“the GP”) at a Medical Centre in the area of Betsi Cadwaladr University Health Board on 5 December 2017. Ms A said that the GP failed to diagnose a serious heart condition and admit her to hospital.

The Ombudsman’s investigation concluded that the GP’s management of Ms A’s care was reasonable and appropriate. The Ombudsman was satisfied that Ms A’s complex heart condition (infective endocarditis) could only be diagnosed with specialist scans. The Ombudsman therefore did not uphold Ms A’s complaint.

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

[Case Number: 201800328– Report published in March 2019](#)

Miss A complained that despite repeated attendances at both the Emergency Departments (“ED”) of Abertawe Bro Morgannwg University Health Board’s Singleton Hospital and Murryston Hospital for right sided pain there was a failure to diagnose a large ovarian cyst.

The Ombudsman’s investigation found that Miss A’s care, including investigations and tests, had been reasonable and appropriate. There was no clinical indication to suggest that Miss A had an ovarian dermoid cyst in 2017. It was also very unlikely to have been the cause of her pain, given dermoid cysts are very rare and often asymptomatic. He did not uphold Miss A’s complaint.

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

[Case Number: 201801475 – Report published in March 2019](#)

Mrs A complained that the care and treatment provided to her son, Mr B, between 24 May and 10 June 2016 at Prince Charles Hospital (“the Hospital”) was not adequate. She also complained that considering her son’s presenting symptoms, it was inappropriate that he was not admitted to hospital on 10 June.

The Ombudsman’s investigation found that Mr B already had an advanced cancer by the the time he first presented at hospital. He received timely and appropriate care and was regularly reviewed by a range of specialists. When Mr B was reviewed on 10 June, there were no clinical signs that he needed to be admitted. The Ombudsman therefore did not uphold this complaint.

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

[Case Number: 201708038 – Report published in March 2019](#)

Mrs X complained that her new-born baby did not get the medical intervention he needed in respect of tongue-tie. She said that because of her child’s condition he was unable to breast feed. She was of the view that the feeding problems her son had were because of the tongue-tie which she felt should have been identified before her discharge home from the Maternity Unit of Nevill Hall Hospital. Mrs X also complained that she was told by a midwife that her son had tongue-tie and would be referred to a paediatrician, but this did not subsequently happen.

The investigation found that Mrs X’s child had significant tongue-tie and this, seemingly, led to ongoing

feeding problems. However, given that the records indicated that Mrs X's child was feeding adequately from the breast, we could not find that the tongue-tie was unreasonably missed by staff on the Maternity Ward before Mrs X and her son were discharged. With respect to the complaint about the comment allegedly made by the midwife, due to the irreconcilable and conflicting accounts, the investigation could not conclude that the comment had, in fact, been made to Mrs X. The complaint was, therefore, **not upheld**.

## Early Resolution or Voluntary Settlement

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case Number: 201804938 – Report issued in January 2019

Mr X complained about the care he received from the Health Board during an extended stay at the hospital. Mr X previously complained to this office and it was agreed that the Health Board will provide an independent report and provide him with the full set of clinical notes. Mr X explained that he has not yet received the independent report nor the full set of records.

The Ombudsman found that although 3 month seems rather excessive to appoint an Independent expert. The Health Board have now confirmed that it aim to response within 10 weeks. There also seemed to be a dispute whether the Health Board had shared the clinical records relating to the shunt procedure. The Health Board agreed to undertake the following action, on receipt of the Ombudsman's decision, in settlement of the complaint.

- a) Provide Mr P with the clinical records within 1 month

Hywel Dda University Health Board - Appointments/admissions/discharge and transfer procedures

Case Number: 201804937 – Report issued in January 2019

Mr X complained to the Ombudsman about the delay in Hywel Dda University Health Board's ("the Health Board") complaints handling process.

Mr X first complained to the Health Board in April 2018 and has yet to receive a full response under the Putting Things Right regulations.

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

- a) to apologise for the delay
- b) to expedite a full response to Mr X's complaint within 10 days of the date below (11 January 2019)

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201805148 – Report issued in January 2019

Mr A complained about the care and treatment provided to his late mother, Mrs A, during the admission before her death and that the medical notes relating to the admission had been mislaid by the Health Board.

The Ombudsman contacted the Health Board to express his concern that the records were missing and that this would deny Mr A the opportunity to have his complaint reviewed by his office. He confirmed that the loss was a serious matter and evidence of maladministration on the Health Board's part that had resulted in a significant injustice to Mr A. The Health Board agreed to provide Mr A with an appropriate apology and a payment of £1750 in recognition of the uncertainty and distress caused to Mr A due to its administrative failing.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201804899– Report issued in January 2019

Mrs W complained that she had not received dental treatment she required for a cleft palate condition.

Her last appointment on 18 October 2018 had been cancelled and she had discovered that the Consultant overseeing her treatment was on long term sick leave.

The Ombudsman was unable to intervene in a decision regarding her treatment. He was, however, of the view that the Health Board should provide Mrs W with an explanation regarding her ongoing treatment. It has agreed to;

- (a) Write to the complainant and provide her with an explanation of the current situation regarding her treatment.

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

The Ombudsman believes that this will provide a resolution to this complaint.

## [Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201805773– Report issued in January 2019](#)

Mr S complained that Abertawe Bro Morgannwg University Health Board (“the Health Board”) had taken several months to advise him that a camera capsule had become dislodged and remained in his lower bowel following an endoscopy procedure in February 2018.

He also complained that the Health Board had failed to fully respond to his complaint about that issue and its general lack of communication.

The Ombudsman found that the Health Board had advised Mr S of the risks involved in the procedure prior to him agreeing to it. One of the risks was the possible retention of the camera capsule. It had apologised for the delay in providing the result of the procedure due to a technical error.

The Ombudsman, however, was of the opinion that the Health Board needed to undertake further work to resolve Mr S’ complaint. He contacted the Health Board and it agreed to;

- (a) Write a letter to him, providing him with a response to the issues raised and listed in his letter to the Health Board; and
- (b) Summarising any further involvement by the Health Board in his ongoing care and treatment since November 2018 until the present date.

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

The Ombudsman believes that this will resolve his complaint.

## [Hywel Dda University Health Board - Clinical treatment in hospital](#) [Case Number: 201805862 – Report issued in January 2019](#)

Mrs A complained about the care and treatment leading up to the sad death her baby whilst at Glangwili Hospital. Mrs A also complained about the delay in the Health Board responding to her complaint.

Although the Health Board had provided updates to Mrs A whilst its investigations were on going, the Ombudsman proposed it complete the following in settlement of Mrs A’s complaint:

- (a) Issue its final ‘Putting Things Right’ response by 31 January 2019
- (b) Apologise to Mrs A for the delay in responding to her complaint

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

## Case Number: 201806213 – Report issued in January 2019

Miss E complained about the care and treatment that was provided to her late father. Miss E also complained about the delay in the Health Board offering to arrange a requested meeting between Miss E's family and the Health Board.

The Health Board agreed to do the following in resolution of the complaint:

- a) Arrange a meeting between the family and key staff at the Health Board, to allow the family an opportunity to discuss their concerns.

The Health Board has agreed to complete the above by no later than 14 February 2019.

## Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

### Case Number: 201805827 – Report issued in January 2019

Ms E complained about the Health Board's response to her complaint about her late father Mr S's care. She said that the response had not addressed the main point of her complaint.

The Ombudsman noted that Mr S's care had been provided by both ABMU and Hywel Dda Health Boards. However, the response provided to Ms E only dealt with the care provided by ABMU. A joint response covering the care provided by both Health Boards should have been given.

Therefore, the Health Board:

- a) Agreed to provide an additional response to Ms E (within 6 weeks) covering care provided by both Health Boards
- b) Offered Ms E a meeting with the consultant to discuss any concerns she had about Mr S's diagnosis.

## West Quay Medical Centre - Clinical treatment outside hospital

### Case Number: 201805196 – Report published in February 2019

Ms B complained to the Ombudsman about West Quay Medical Centre following a prescribing error when the wrong medication was dispensed with a repeat prescription.

The Ombudsman contacted the West Quay Medical Centre to discuss the complaint and it has agreed to take the following action:

- a) To undertake a significant event analysis
- b) To undertake a systems analysis with the Centre's Pharmacist
- c) To provide Ms B with a formal report by 20 February 2019; which will include any lessons learned and changes to be implemented as a result of the review

## Betsi Cadwaladr University Health Board - Clinical treatment in hospital

### Case Number: 201805390 – Report published in February 2019

Mr B complained to the Ombudsman about the delay in obtaining an appointment for a family member to undergo a neurodevelopmental assessment. Mr B said that he contacted the Health Board several times between October 2018 and December 2018 but failed to receive a response to his repeated requests for an update.

The Health Board agreed to the following recommendations:

- (a) Provide a meaningful apology to Mr B
- (b) Make a payment of £50 to Mr B for the time and trouble taken

(c) Expedite a full response to Mr B's concerns

## [Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures](#) Case Number: 201806445 – Report published in February 2019

Mr X contacted the Ombudsman to complain about the difficulty he had experienced when a scheduled appointment at a Hospital within the Betsi Cadwaladr University Health Board (“the Health Board”) locality was rearranged. Mr X said that, despite complaining to the Health Board, he was still waiting for the Health Board's explanation.

The Ombudsman's office contacted the Health Board. It agreed to provide a response to Mr X within 20 working days of this summary.

## [Powys Teaching Health Board - other](#)

### Case Number: 201805710 – Report published in February 2019

Ms A complained that the Health Board had failed to properly deal with, and respond to, her Independent Patient Funding Request (“IPFR”). In accordance with the Ombudsman's jurisdiction the complaint to this office was premature, as the Health Board had not received nor had an opportunity to respond to the complaint. However, to assist Ms A to progress her substantive complaint, the Health Board was contacted on receipt of her complaint.

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

1. Once the Health Board has received the complaint, it will put it through its formal complaints process, investigate and respond to the concerns directly. The Health Board has agreed to contact Ms A to discuss this process with her.
2. If, during its investigation of the complaint, the Health Board identify failings in the way her IPFR request was processed, it has agreed to deal with Ms A's IPFR request in accordance with its due process.

The Ombudsman thinks that the action which the Health Board has said it will take is reasonable and will also resolve your substantive complaint.

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

### Case Number: 201806353 – Report published in February 2019

Miss R complained that the Board had failed to provide her with a care plan for the chronic pain she was suffering as a result of ongoing medical problems. She also felt that she should have been consulted regarding this and a decision that was made by her Consultant not to refer her for hydrotherapy.

The Ombudsman found that the Board had reconsidered and offered Miss R a referral to hydrotherapy. He contacted the Board and it agreed to;

- (a) review her care and treatment and write to her providing her with its proposed care plan.
- and
- (b) provide her with a hydrotherapy appointment as soon as one became available as promised in its response letter to her dated 11 January 2019.

The letter should be sent within 20 working days of the date of my decision letter (19 March 2019).

The Ombudsman is satisfied that this will provide a reasonable resolution to her complaint.

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

### Case Number: 201805931 – Report published in February 2019

Miss Z complained about the care and treatment she received at two hospitals in the Health Board's area,

specifically that there was a bloodstained swab on a bed when she entered a treatment room and that the Health Board failed to adequately manage her pain following the insertion of an IV cannula.

The Ombudsman noted that the Health Board had appropriate Infection Control policies in place, was undertaking regular audits to ensure compliance with those policies and had apologised to Miss Z for the presence of the bloodstained swab. The Ombudsman did not consider that anything further could be achieved in investigating the Infection Control matter.

The Ombudsman found that the Health Board had failed to respond to Miss Z's pain management concerns, and also noted that it had not recorded the insertion of the IV cannula in Miss Z's medical records. The Health Board therefore agreed to complete the following by 9 April 2019 in settlement of Miss Z's complaint:

- a) Apologise for failing to respond to Miss Z's pain management concern;
- b) Issue a 'Putting Things Right' response to the pain management concern; and
- c) Remind relevant Emergency Department staff that cannula insertion should be documented in a patient's notes.

#### [Hywel Dda University Health Board - Clinical treatment in hospital](#) Case Number: 201805786 – Report published in February 2019

Mr A complained that the Health Board refused to carry out a scan on his late father after being referred by his GP. He also complained of the delays in carry out the scan once the Health Board had agreed to undertake it. This led to a delay in diagnosis and treatment.

Mr A also complained of the Health Board's failure to respond to his complaint within six months. The Health Board acknowledged there had been a delay and offered to carry out the following in settlement of Mr A's complaint by **18 February 2019**:

- a) Write to Mr A to advise of the current position.
- b) Apologise for the delay in responding to his complaint.
- c) Offer £250 in recognition of the impact of its delayed complaint handling.

#### [Powys Teaching Health Board – Continuing Care](#) Case Number: 201805845 – Report published in February 2019

Mr X complained that the Health Board had not properly assessed eligibility for continuing healthcare (CHC) funding when his partner, Ms B, was discharged from hospital to their home in September 2016. He said that CHC eligibility and the fact that it could apply equally to someone who is cared for at home was not discussed with the family at the time.

The Health Board had apologised that it should have explained the nature of assessments done at the time of Ms B's discharge from hospital.

The Health Board agreed:

- To carry out a clinical review of Ms B's medical and nursing records (at the time of and subsequent to her discharge from hospital to her home in September 2016) to assess whether she met the eligibility criteria for CHC funding during that period;
- To contact Mr X about the review and inform him about the outcome in writing;
- To complete the review by Friday 1 March.

#### [Abertawe Bro Morgannwg University Health Board – Other](#) Case Number: 201804653 – Report published in February 2019

Mr A complained that the package of care provided to his son by an independent Care Provider on behalf

of the Health Board and the local Council was taken away from his family incorrectly, and without proper consultation. He also complained that questions he raised with the Health Board were not answered properly, and it did not properly address complaints about staff members.

Although the Ombudsman declined to investigate Mr A's complaint, he was concerned that some issues had not been clearly addressed with Mr A and his family. Because of this he contacted the Health Board who agreed to do the following:

- (a) To write to Mr A to clarify where the responsibilities lie between the Health Board and local Council;
- (b) To respond to two separate complaints about the care provided by members of the Health Board's staff;
- (c) To write to Mr A to advise about the opportunity for short breaks.

#### [Cardiff and Vale University Health Board - Clinical treatment outside hospital](#) Case Number: 201805655 & 201805744 – Report published in February 2019

Mr A complained that the Community Mental Health Team (which is managed jointly by Cardiff and Vale University Health Board and Cardiff Council) had not provided him with reasonable care and treatment. Mr A complained that the Community Mental Health Team had failed to provide him with a Care and Treatment Plan for over two years.

Although the Ombudsman declined to investigate Mr A's complaint, he was concerned that there had been a considerable delay in providing Mr A with a Care and Treatment Plan.

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

- (a) Apologise to Mr A for the considerable delay in providing him with a Care and Treatment Plan;
- (b) Provide Mr A with an up-to-date Care and Treatment Plan within the next 28 days;
- (c) Offer Mr A a payment of £1,000 in total for failing to provide him with a Care and Treatment Plan for over two years.

#### [Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201805373 – Report published in February 2019

Ms A complained about the events leading to the death of her brother, Mr B, who had died at a residential Unit ("the Unit") in England (in 2016) from an undetected / untreated bleed on his brain. The Health Board had commissioned and arranged for Mr B's care at the Unit. Ms A had complained about the Health Board's monitoring of Mr B's care and placement at the Unit. She felt his death might have been prevented and raised Article 2 matters. There was an outstanding Coroner's inquest and an incomplete Health Board Serious Incident Review into Mr B's death. Ms A had also made a second complaint to the Health Board about the manner in which a named officer had spoken with her, and the termination of a telephone call (in May 2018). She was unhappy with the Health Board's response to that complaint, which declined to investigate it.

Having considered the evidence before him, the Ombudsman declined to investigate the substantive issue about Mr B's care and death, for jurisdictional reasons. Ms A had already expressed an intention to pursue a legal claim and had instructed solicitors. The Health Board was dealing with the matter as a legal claim. The Ombudsman was satisfied that there was another remedy reasonably available to Ms A.

The Ombudsman found that Ms A's second complaint was a separate and distinct matter, and the Health Board ought to have considered, investigated and responded to it. After contacting the Health Board, it agreed to the following in resolution of the complaint:



- (a) To apologise in writing (within one month) to Ms A for the failure to progress her second complaint and provide a formal reply to it
- (b) To undertake the investigation of the second complaint, providing Ms A with a response within two months.

## Cwm Taf University Health Board – Other

Case Number: 201805750 – Report published in February 2019

Mrs C complained, as part of a wider complaint, that the Health Board failed to investigate her complaints that both the Health Board and the GP practice did not make reasonable adjustments to ensure that her husband, Mr C, received an adequate service in the two years leading up to his death. Mrs C said that this failing impacted on his care and may have contributed to Mr C's deterioration.

The Health Board addressed most of Mrs C's complaint but acknowledged it had overlooked this element of the complaint. It agreed to undertake an investigation.

## Betsi Cadwaladr University Health Board – Confidentiality

Case Number: 201807496 – Report published in March 2019

Mrs X told the Ombudsman that despite making a complaint to the Health Board, she has received no reply or contact from it.

The Ombudsman found that although Mrs X raised a complaint, the Health Board did not have any record of it.

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

- (a) Apologise to Mrs X for the delay in considering her complaint
- (b) Provide Mrs X with a response within one month of the date of this decision.

## Abertawe Bro Morgannwg University Health Board - Continuing care

Case Number: 201806180 – Report published in March 2019

Mrs W complained to the Ombudsman about the manner Abertawe Bro Morgannwg University Health Board ("the Health Board") had considered the eligibility of her late mother (Mrs X) for NHS Continuing Healthcare ("CHC"). In particular Mrs W had said that she and other family members were unaware of the implications of the differences between CHC and Funded Nursing Care ("FNC") at the time her mother had been discharged from hospital to a care home and that they were unaware of the process for appealing the decision until it was too late for them to make a retrospective claim for CHC for the full period her mother had been in the care home.

The Ombudsman found no evidence that Health Board had explained to Mrs W the process for appealing a CHC decision if she was unhappy with the decision. Neither was there any evidence available that the Health Board had written to Mrs W explaining the decision that whilst Mrs X was eligible for FNC, she was not eligible for CHC.

By way of an early resolution, the Health Board agreed to undertake a retrospective review of Mrs X's eligibility for CHC for the period she had spent in the care home which had not been considered by it previously.

## Betsi Cadwaladr University Health Board - Clinical treatment outside hospital

Case Number: 201806733 – Report published in March 2019

Mr X complained to the Ombudsman about the care he received from the Health Board whilst he was a prison inmate. He was particularly concerned about the Health Board's failure to provide him with dentures in a timely manner and its refusal to provide him a sufficiently high dose of pain medication upon

transfer to the Health Board area.

The Ombudsman found that whilst Mr X had received a response to his concerns, these had been an informal “on the spot” response and had not been considered as a formal complaint under the NHS’s formal complaints procedure, “Putting Things Right” (“PTR”).

The Health Board agreed to investigate Mr X’s concerns formally under PTR and to provide him with a final response to his concerns by 18 April 2019.

#### [Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201806401 – Report published in March 2019](#)

Ms X complained about her mother’s care (“Mrs A”) at the Health Board, specifically an episode which she said was traumatic and demonstrated that Mrs A was showing signs of recovery. Ms X also complained that she had not received an unspecified questionnaire or Mrs A’s patient diary from the Health Board.

The Ombudsman concluded that an investigation into Mrs A’s care was unlikely to establish whether there was any service failure, or establish whether her care caused a significant injustice to her. The Ombudsman was satisfied that there was no service failure in respect of Ms X’s questionnaire complaint but contacted the Health Board in respect of Mrs A’s patient diary. The Health Board agreed to carry out the following in settlement of the complaint:

- a) Within two weeks, provide Ms X with a copy of Mrs A’s patient diary.

#### [Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201807690 – Report published in March 2019](#)

Mrs J complained that there were factual anomalies within two letters received from the Health Board. Mrs J also listed a number of inconsistencies relating to the investigation outcome, plus concerns about the Health Board’s complaints procedure.

By way of resolution, the Ombudsman proposed the following:

#### **By 12 April 2019**

1. A meeting take place between Mrs J and the Health Board, which would allow an opportunity to address Mrs J’s concerns.
2. The Health Board agreed to arrange a meeting, however, on the instruction of Mrs J are now awaiting further contact from her advocates to arrange the meeting.

#### [Abertawe Bro Morgannwg University Health Board- Clinical treatment in hospital](#) [Case Number: 201807721– Report published in March 2019](#)

Mrs S complained about the care and treatment provided to her late husband. Mrs S says that the Health Board failed to identify renal cancer, even though her husband was being monitored for what they were advised was a simple non-malignant renal cyst, however, further scans identified metastatic renal malignancy. Mrs S also complained about the delay in the Health Board’s response.

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

#### **By 25 April 2019:**

- a) Apologise to Mrs S for the delay.
- b) Provide a full written response addressing Ms S’s concerns.
- c) Offer Mrs S a meeting to discuss her concerns.

- d) Offer Mrs S a redress payment of £250.00 for poor complaint handling.

## Agriculture and Fisheries

### Early Resolution or Voluntary Settlement

Rural Payments Wales - Payment schemes

Case Number: 201805180 – Report issued in January 2019

Mr A complained to Rural Payments Wales (RPW) about the delay in its handling of his appeal about an application to transfer to a "Glastir Organic contract". Mr A had lodged his appeal in March 2018. He complained about the overall delay, that he had not been provided with any update unless he contacted RPW himself, and that he had not had a response from RPW to his complaint about this. He sought an outcome by way of his Stage 2 appeal being dealt with "urgently".

Owing to restrictions under the Act governing the Ombudsman's work, he was unable to question the process which RPW had adopted to deal with appeals (in strict date order of receipt). RPW had responded to Mr A's complaint, albeit it appeared Mr A had not received that letter. The Ombudsman was concerned at the level of apparent delay overall, and sought assurance about the current position regarding all appellants. Further, he considered that there had been a failing to proactively keep Mr A updated. Therefore, the Ombudsman sought RPW's agreement to the following recommendations (which it agreed to implement):

- (a) To apologise to Mr A in writing for the 9 month, and ongoing, delay in setting the Stage 2 Panel / appeal hearing (within one month)
- (b) To provide Mr A with an update as to when it is likely his appeal might be determined and, in any event, to arrange a hearing in the next 3 months.

## Complaints Handling

### Upheld

Aneurin Bevan University Health Board - Health

Case Number: 201707517 – Report issued in January 2019

Mr D complained about failings in his late wife, Mrs D's, care in relation to knee surgery; in particular he was concerned about:

- Whether Mrs D was fit to undergo knee surgery
- The care Mrs D received following her transfer to a second hospital
- Failings in communication with him and his family.

The Ombudsman concluded Mrs D had been fit for surgery. However, he found delays in Mrs D being seen by a medical team when it was believed she might have pneumonia. If she had been seen earlier, Mrs D might have been transferred to the ITU earlier; although the Ombudsman could not say this would have altered the outcome for Mrs D, she would have been given a better chance of survival. The Ombudsman also found failings in the Health Board's communication with Mr D and his family. He partly upheld the complaint.

The Ombudsman recommended the Health Board apologise to Mr D and make a payment to him of £500 in recognition of the distress caused. He also recommended training for clinical staff, as well as a review

of the arrangements for urgent X-rays to be carried out.

## Betsi Cadwaladr University Health Board – Health

Case number: 201800976 – Report issued in March 2019

Mrs A and Miss B complained about the care and treatment received by their late father, Mr C, from Betsi Cadwaladr University Health Board (“the Health Board”). In particular, they complained that Mr C was made to wait an unreasonable amount of time in Accident and Emergency (“A&E”) before being transferred to a ward; intravenous (“IV”) fluids were not prescribed soon enough, the IV fluids caused Mr C to develop fluid on his lungs; the diagnosis of neutropenic sepsis was not communicated clearly to the family, and that the private room that Mr C was moved to was unfit for purpose.

The Ombudsman's investigation found that Mr C's wait time in A&E fell broadly within NHS targets, his IV fluid was commenced in a timely manner, his medical records documented discussions taking place with the family about sepsis, and that there was no evidence that the private room was unfit for purpose. These aspects of the complaint were therefore not upheld.

The investigation found, however, that the rate at which IV fluid was administered was inappropriate and caused Mr C to develop fluid on his lungs. The Ombudsman therefore upheld this part of the complaint. The Ombudsman recommended that the Health Board apologise to Mrs A and Miss B for the failings identified, remind all staff of the importance of appropriate IV fluid prescribing and monitoring, and review its policy and procedures for IV fluid management. He also recommended that the Health Board make a redress payment to the family in recognition of distress and uncertainty caused by the failings in Mr C's care and treatment.

## Not Upheld

Hywel Dda University Health Board - Health

Case Number: 201706610 – Report published in February 2019

Ms X complained that the surgery undertaken on the foot/ankle injury she sustained after a car accident in October 2015, and the subsequent care for that injury, had not been of a reasonable standard (which includes the delay in undertaking further surgery on the foot/ankle). She was aggrieved that she had been in full time employment before the accident but was now unable to work because of the pain and swelling she continued to experience.

The investigation found that the care and treatment provided to Ms X by the Orthopaedic Team appeared to have been of a reasonable and acceptable standard. The fact that Ms X's injury had not resolved satisfactorily after her initial operation in October 2015 was not compelling or persuasive evidence that the surgery had not been performed to a reasonable standard.

Furthermore, the investigation found that there was no unreasonable delay on the part of the Orthopaedic Team in undertaking additional surgery in light of Ms X's ongoing problems. Ms X was seen in regular clinics and efforts were made to investigate and address her ongoing problems.

The complaint was **not upheld**.

## Early Resolution or Voluntary Settlement

Hywel Dda University Health Board - Health

Case Number: 201805699 – Report issued in January 2019

Miss X complained that the Health Board had failed to respond to the concerns she had raised regarding its treatment of issues related to her fallopian tubes.

The Health Board informed the Ombudsman that it was in the process of facilitating a meeting between Ms X and the relevant clinician. The Health Board therefore agreed to complete the following in settlement of Miss X's complaint:

By 13 March 2019:

- a) Apologise to Miss X for the delay in arranging a meeting
- b) Provide Miss X with a date for the meeting.

Within 30 working days of the meeting:

- a) Issue a 'Putting Things Right' response to Miss X.

## Isle of Anglesey County Council - Housing

Case Number: 201806091 – Report issued in January 2019

Mr X complained that the Council had failed to respond to his complaints about its delays in completing a form enabling him to sell on an ex-Council property.

In response to the Ombudsman's enquiries, the Council confirmed that a complaint response should have been issued under Stage 1 of its complaints procedure in November 2018. As this had not happened, the Council therefore agreed to complete the following actions in settlement of the complaint:

- a) Apologise for the complaint handling delays Mr X experienced
- b) Issue the Council's response at Stage 2 of its complaints procedure
- c) Make a payment of £50 to Mr X in recognition of the Council's complaint handling delays and for the time and trouble in making his complaint to the Ombudsman.

The Council's letter to Mr X dated 29 January 2019 evidenced that it had complied with the actions outlined above.

## Abertawe Bro Morgannwg University Health Board - Health

Case Number: 201805970 – Report issued in January 2019

Mr X complained that the Health Board failed to address all of his concerns in its 'Putting Things Right' ("PTR") response of 9 October 2018, regarding the treatment provided to his deceased uncle.

The Ombudsman found that the Health Board had failed to address all of the concerns in its PTR response to Mr X. The Health Board therefore agreed to complete the following in settlement of Mr X's complaint by 7 March 2019.

- a) Apologise to Mr X for the failure to address all of his concerns in its original PTR response
- b) Provide an explanation to Mr X as to why it is only now that his complaint has been made to the Ombudsman that it feels its PTR response needs to be reviewed
- c) Issue a new PTR response.

## Neath Port Talbot County Borough Council - Environment and Environmental Health

Case Number: 201804686 – Report issued in January 2019

Mr A complained about a change in waste collection arrangements by the Council (without prior notice), about the manner in which an officer spoke with him, and about how the Council handled his complaint. He said that he had not had a reply to all the questions he had first asked back in November 2017.

The Ombudsman could not question a policy decision taken by the Council to change waste collection arrangements from certain properties. However, on the evidence before him, and as confirmed by the Council, the Ombudsman was satisfied that the Council had failed to log Mr A's earlier contacts as a formal complaint. It should have done. It was also clear that the Council's response had not answered all

of Mr A's legitimate questions about the change in arrangements. By way of resolving the complaint handling concerns, the Council agreed to implement the following actions proposed by the Ombudsman (all within 20 working days):

- (a) To provide Mr A with a written apology for failing to record his legitimate concerns as a formal complaint;
- (b) To provide Mr A with a response to all his listed concerns (a stage 2 complaint response);
- (c) To offer Mr A redress of £100 for his time and trouble in pursuing these issues with the Council and with the Ombudsman's office.

## [Aneurin Bevan University Health Board - Health](#)

[Case Number: 201805949 – Report published in February 2019](#)

Mrs X complained that the Health Board had failed to respond to the complaint she made to it in May 2018 about the treatment it provided to her following an ear injury.

The Ombudsman found that the Health Board had proactively updated Mrs X during the first four months of its investigation, but, following its letter of 19 September 2018, Mrs X had to chase the Health Board for updates.

The Health Board therefore agreed to complete the following actions by 6 March 2019 in settlement of Mrs X's complaint:

- a) Apologise to Mrs X for the delays she had experienced and for failing to update her following the holding letter of September 2018
- b) Issue the 'Putting Things Right' response
- c) Make a payment of £75 to Mrs X for the lack of updates provided and for the time and trouble in making her complaint to the Ombudsman.

## [Powys County Council - Housing](#)

[Case Number: 201806022– Report published in February 2019](#)

Mrs A complained that the Council had failed to respond to her complaint about housing repairs which was referred to it by the Ombudsman in September 2018.

The Council informed the Ombudsman that the complaint had not been logged correctly and therefore agreed to complete the following actions by 20 March 2019 in settlement of Mrs A's complaint:

- a) Apologise to Mrs A that her complaint had not been logged correctly
- b) Issue a complaint response at Stage 2 of its complaints procedure
- c) Make a payment of £125 to Mrs A for failing to log her complaint correctly and for the time and trouble in making a further complaint to the Ombudsman.

## [Conwy County Borough Council - Adult Social Services](#)

[Case Number: 201806067– Report published in February 2019](#)

A solicitor complained on behalf of Mr X that the Council had failed to respond to his complaint, made to it in October 2018, regarding Social Services support for Mr X's profoundly autistic son, Mr Y.

The Council informed the Ombudsman that it had not responded to the complaint due to a misunderstanding. The Council therefore agreed to complete the following actions by 13 March 2019 in settlement of Mr X's complaint:

- a) Apologise for the complaint handling delays
- b) Issue its Stage 1 Social Services complaint response

- c) Make a payment of £100 to Mr X for the delays and as a contribution to any costs incurred as a result of his solicitor having to chase the Council for a complaint response.

## Powys Teaching Health Board – Health

Case Number: 201806472– Report published in February 2019

Mrs A complained about the Health Board's handling of her complaint, made to it in May 2018, regarding the treatment she received from her GP dating back to 1994.

The Health Board received all relevant documentation from Mrs A in August 2018. Mrs A subsequently chased the Health Board for updates in October 2018 and January 2019. The Health Board, in updating Mrs A, offered its apologies for the complaint handling delays.

The Health Board wrote to Mrs A on 23 January 2019 to advise that the medical records dating back to 1994 had been destroyed in line with its 'Retention and Destruction of Records' policy. The Health Board again apologised for the way in which it had handled Mrs A's complaint. The Health Board's letter, however, did not clarify whether it would continue to investigate Mrs A's complaint.

The Health Board therefore agreed to write to Mrs A by 8 March 2019 in order to clarify whether it would progress with consideration of the complaint, given that Mrs A's records have been destroyed.

## City and County of Swansea – Various Other

Case Number: 201807045 – Report published in February 2019

Mr X complained that the Council had failed to respond to his concern, made to it in December 2018, following a Fixed Penalty Notice he had received.

The Council confirmed to the Ombudsman that Mr X's concern had been received and passed to the relevant department for a response; however, the response was not issued. The Council therefore agreed to complete the following by 21 March 2019 in settlement of Mr X's complaint:

- a) Apologise for the delay in responding to the complaint
- b) Issue a complaint response at Stage 2 of its complaints procedure.

## Hywel Dda University Health Board – Health

Case Number: 201806106 – Report published in February 2019

Mrs X complained that the Health Board had failed to respond to her complaint about the treatment provided to her father, which she made to it in September 2018.

The Ombudsman found that the Health Board had failed to provide meaningful updates to Mrs X during the course of its investigation. The Health Board agreed to complete the following in settlement of Mrs X's complaint by 19 March 2019:

- a) Apologise to Mrs X for the delay in responding to her complaint, and for its failure to provide meaningful updates
- b) Issue its final PTR response.

## City and County of Swansea - Children's Social Services

Case Number: 201806459 – Report published in February 2019

Mr X complained that the Council had failed to respond to his complaint about its Children's Services Department instigating an investigation against him.

The Ombudsman found that the Council had provided updates to Mr X during the course of its investigation, but had failed to issue a formal response. The Council agreed to complete the following in settlement of Mr X's complaint by 20 March 2019:

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

[Betsi Cadwaladr University Health Board - Health](#)

[Case Number: 201806562 – Report published in February 2019](#)

Mrs X complained that the Health Board had failed to provide its final response to her complaint about the treatment provided to her late father, which she initially made on 5 October 2018, with additional concerns being added on 15 November 2018.

The Health Board agreed to complete the following in settlement of Mrs X's complaint by 7 March 2019:

- a) Issue its final PTR response.

[Betsi Cadwaladr University Health Board - Health](#)

[Case Number: 201805768 – Report published in February 2019](#)

Mr A complained that the Health Board had prepared inaccurate or otherwise misleading medical records in relation to an operation he received some years earlier. Mr A was concerned that the lack of accurate detail within his medical records had resulted in his on-going treatment being based on incorrect information.

Although the Ombudsman declined to investigate Mr A's complaint, he was concerned that Mr A's medical records did not fully reflect the seriousness of the operation.

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

- (a) To add to or amend Mr A's medical records to ensure that they accurately reflected the significance of the surgery he had received and the issues with his on-going care;
- (b) To apologise to Mr A.

[Blaenau Gwent County Borough Council - Education](#)

[Case number: 201806713 – Report issued in March 2019](#)

Mr X complained that, he has received no contact from the Council in response to his concern. Mr X sent an email to the Leader of the Council along with the Executive Member for Education. Mr X's AM also forwarded his email to the managing director and received no response.

The Ombudsman found that although Mr X raised his concerns, the Council sent a response to his AM and not Mr X.

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

1. Provide Mr X with a copy of the response originally sent to your AM
2. Provide Mr X with information of the Stage 2 complaint procedure.

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

[Case number: 201806869 – Report issued in March 2019](#)

Mr D complained that the Health Board had failed to fulfil its offer of a local resolution meeting with him following an agreed review of his complaint to it in 2018. It had also failed to provide him with a detailed response to its review of his complaint within the agreed time limit.

The Ombudsman contacted the Board agreed to write a letter to the complainant.



- 1) Apologising for not providing him with the correct detailed response within the time limit agreed by it in October 2018.
- 2) Arrange to meet with him as previously agreed by it and
- 3) Offer a payment to him of £150 for time and trouble taken in pursuing his complaint.

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

The Ombudsman is satisfied that this will resolve his complaint.

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

[Case number: 201807701 – Report issued in March 2019](#)

Mr D complained that there has been a delay in the Health Board issuing its Putting Things Rights (“PTR”) response, and apart from the issued holding letters, it has not issued any meaningful update to Mr D as to when it is likely to send its response.

The Health Board has acknowledged that there have been delays in the finalisation of its investigation and has agreed to the following in resolution of the complaint, which the Ombudsman thinks is reasonable.

By 29 March:

- a) Issue its formal PTR response

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

[Case number: 201806715 – Report issued in March 2019](#)

Mr X complained to the Ombudsman that the Health Board had failed to respond to his concerns surrounding the death of his father from a cardiac arrest shortly after being given anaesthetic and prior to moving him to another hospital.

The Health Board confirmed to the Ombudsman there had been a delay in receiving comments from a key clinician, needed to reply to Mr X's complaint. Those comments had been received and the investigation was nearing conclusion. It therefore agreed to issue its response to Mr X no later than **29 March 2019**.

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

[Case number: 201806524 – Report issued in March 2019](#)

Mr X complained that the Health Board had not addressed the concerns that he raised in relation to his treatment.

The Ombudsman noted that, whilst staff had met with Mr X, the Health Board had not provided a written response to his concerns about his treatment, nor did it have a record of what had been agreed at the meeting. Under the ‘Putting Things Right’ regulations, the Health Board should have given a formal written response to Mr X's complaint.

The Health Board therefore agreed to:

1. Contact Mr X and arrange to meet with him to discuss his concerns about his treatment within one month (**i.e. by 4 April 2019**).
2. Provide a written response to Mr X's complaint in line with the NHS complaints procedure (“Putting Things Right”), including an apology for not responding to his concerns formally in writing in the first instance (within two weeks of the date of the meeting).

## [Gwynedd Council – Housing](#)

[Case number: 201807150 – Report issued in March 2019](#)

Miss X complained that the Council had failed to respond to her complaint about the conduct of its officer, which she made to it in October 2018.

The Ombudsman found that although the Council could produce a copy of its response it had no proof of postage. The Council, in settlement of Miss X's complaint, agreed to reissue its response by 21 March 2019.

## Denbighshire County Council - Roads and Transport

### Case number: 201807162 – Report issued in March 2019

Mrs X complained that the Council had failed to respond to her complaint about the poor installation of a drain opposite her property, which she made to it in January 2019.

The Ombudsman found that the Council had failed to acknowledge Mrs X's complaint. The Council agreed to complete the following in settlement of Mrs X's complaint by 12 April 2019:

- a) Apologise to Mrs X for the delay in responding to her complaint, and for its failure to provide an acknowledgement
- b) Issue its stage two response.

## Education

### Not Upheld

#### Denbighshire County Council - Special Educational Needs (SEN)

##### Case Number: 201703811 & 201802642 – Report issued in January 2019

Mr A complained that Denbighshire County Council ("the Council") had been overly restrictive in its application of its policy for dealing with unacceptable customer behaviour ("the Policy"). He also complained that, as a result, the Council had failed to fulfil its statutory obligations in relation to his daughter's ("Ms B's") Special Educational Needs ("SEN") by failing to work in partnership with him during Ms B's assessment and appeal. Mr A further complained that the Council had failed to respond to his complaint of 26 May 2018.

The Ombudsman was satisfied from the evidence seen that the Council's decision to invoke the Policy and restrict the way in which Mr A made contact was a properly made decision which it was entitled to make. It was clear that Mr A deliberately circumvented contact restrictions placed upon him. The evidence showed that the Council regularly reviewed its restrictions on contact from Mr A and communicated its decision and the rationale for it to Mr A, in line with the Policy; however, the Council's review of the decision was not always communicated to Mr A in a timely manner. He found that, whilst this may amount to maladministration, he did not consider that Mr A suffered an injustice as a result, as the restriction remained in place after each review. Despite the restrictions, the Ombudsman was satisfied that Mr A was not prevented from engaging in the statutory process and could have done so had he complied with the Council's requests. This complaint was not upheld.

Mr A complained that the Council failed to work in partnership with him during Ms B's assessment and appeal. Whilst the Ombudsman acknowledged that Mr A made the process very difficult as he continually contravened restrictions placed on him and changed the method by which he allowed the Council to contact him, he was disappointed that the Council failed to engage in any form of mediation with Mr A. The Ombudsman was of the opinion that the Council should have entered into mediation in good faith in the best interests of Mr A's daughter and in line with the SEN Code of Practice. Failure to do so amounted to maladministration which caused Mr A injustice as he was not offered this opportunity. The complaint was partially upheld to this limited extent only. The Ombudsman considered that mediation no longer remained a viable option for these parties.

Mr A was also concerned that the Council failed to respond to his complaint of 26 May 2018. The Ombudsman found that on 3 May evidence showed that Mr A had signed for a letter from the Council which acknowledged Mr A's instruction to the Council to only contact him by mail to a postal address provided by Mr A, and to remove his email address from its system. The Council informed Mr A that it would not act upon or respond to email communication from Mr A as this would contravene Mr A's direct instruction. Mr A's email of 26 May was not in accordance with the agreed channel for communication. The Ombudsman considered the Council was justified in not responding to the email and did not uphold this complaint.

## Early Resolution or Voluntary Settlement

Cardiff Council - Exclusions

Case Number: 201806799– Report published in February 2019

The complainant said that, following her son's permanent exclusion from school in November 2018, Cardiff Council ("the Council") had not arranged education until February 2019. A gradual integration into the child's new school was to start from 4 March but only for one hour a day. The complainant said that her son was depressed as a result of being out of his educational routine and she had been unable to go to work.

It appeared from the papers available to the Ombudsman that the child had missed a substantial number of hours of his education following his exclusion. The Ombudsman considered a document produced by the Welsh Government which confirmed that all learners should receive education fifteen days after an exclusion for five hours a day.

In light of this, the Council agreed to the following settlement: -

- (a) Provide an apology and a detailed explanation regarding the delays in providing full time education to the child.
- (b) If any systemic issues are identified as a result of providing this explanation, it will reflect on these and consider how best to improve its practice in the future in order to comply with the Welsh Government's document.
- (c) Provide the child with extra tuition to allow him the opportunity to catch up with the education he has missed.
- (d) Provide a plan for the child to receive the five hours a day education around the one hour a day he will receive at school from 4 March.

## Student Loans Company – Other

Case number: 201804595 – Report issued in March 2019

Miss Q complained that she was advised incorrectly, twice, by the Student Loans Company ("SLC") that she was entitled to a tuition fee loan in her final year of undergraduate study. Miss Q said that she decided to study at undergraduate level, rather than Masters, due to the financial support the SLC said was available.

The Ombudsman noted that the SLC had upheld Miss Q's complaint and so decided that carrying out a full investigation was unlikely to result in a different outcome to that already achieved. However, the Ombudsman noted that the financial redress that had been offered was insufficient and did not reflect fully the injustice Miss Q had suffered due to twice receiving the wrong advice.

To settle the complaint, the SLC agreed to apologise to Miss Q and make a redress payment totalling £650.

## Environment and Environmental Health

### Upheld

Wrexham County Borough Council - Other

Case Number: 201800700– Report published in February 2019

Mrs T complained about the actions of enforcement officers contracted by the Council in issuing a Fixed Penalty Notice (“FPN”) to her partner. She alleged that no offence was committed, and that the officers’ actions were intimidatory and possibly amounted to racial discrimination. She also complained about the way in which the Council responded to her complaint. The Council had accepted that the officers’ attitude was poor and had already cancelled the FPN.

The Ombudsman found no evidence that the officers’ behaviour was racially motivated. However, the Council’s initial response to Mrs T’s representations against the FPN was inadequate. The Ombudsman upheld the complaint to the limited extent of the officer’s attitude and the Council’s initially inadequate response to Mrs T’s representations. He did not uphold the part of the complaint relating to the Council’s complaint handling. In view of the Council’s previous apology to Mrs T, and the fact that it no longer had a contract with the company involved, he did not make any recommendations for redress.

### Early Resolution or Voluntary Settlement

Flintshire County Council - Noise and other nuisance issues

Case Number: 201806340– Report published in February 2019

Ms X complained to the Ombudsman about the length of time the Council had taken to deal with a long-standing planning and statutory nuisance enforcement issue. The Council had not responded to Ms X’s initial complaint which the Ombudsman forwarded to it in August 2018. Following contact from the Ombudsman the Council agreed to provide Ms X with a full complaint response by 21 February 2019 at the latest. The Ombudsman considered this to be a reasonable course of action.

Cardiff Council - Refuse collection, recycling and waste disposal

Case Number: 201807078 – Report published in February 2019

Mr S complained that the Council had failed to collect his garden waste bin on the scheduled date and time. The Council advised that when they attempted to collect his bin, it noticed that the bin was contaminated and arranged for a general waste collection the next day.

The Council agreed to the following by 28 February 2019 in resolution of Mr S complaint:

- a. Write to Mr S to explain the reason why his garden waste bin was contaminated, as this was not clear from its response letter.

Blaenau Gwent County Borough Council - Environment and Environmental Health

Case Number: 201806578– Report published in February 2019

Ms X complained that the Council failed to take appropriate action in relation to a caravan and an untaxed van parked near her home. The vehicles were filled with rubbish and created a health and fire hazard. The owners also fly tipped and failed to pick up dog fouling in the garden, thereby attracting rats.

The Council told the Ombudsman’s office that, at the time Ms X’s complaint was received it was using a new data system. No action was taken in response to Ms X’s complaint.

The Council agreed to undertake the following in settlement of this complaint: -

- a) Start a Stage 2 investigation with an immediate effect.
- b) Issue a response to Ms X no later than **22 March 2019**.

- c) Offer an apology and a redress payment of £250 in recognition of its complaint handling.

#### Flintshire County Council - Other

Case Number: 201805554– Report published in February 2019

Miss X complained about the way in which the Council pursued her in relation to a Fixed Penalty Notice for littering. She denied the incident had occurred in the manner described by the Council and said that it should have ceased proceedings at an earlier stage.

The Ombudsman considered that the Council had taken decisions which it was entitled to and that he could not interfere with the exercise of professional judgement by appropriate officers. However, the Ombudsman did find that the Council had failed both to send some correspondence by recorded delivery and to retain copies of some correspondence. The Ombudsman asked the Council to apologise to Miss X for these failings.

## Finance and Taxation

#### Early Resolution and Voluntary Settlement

Isle of Anglesey County Council – Finance and Taxation

Case Number: 201806622– Report published in February 2019

Mr X complained to the Ombudsman about the failure of Isle of Anglesey County Council (“the Council”) to respond to his correspondence to the Council’s Service. Subsequently, Mr X submitted a complaint to the Council about the lack of response. The Council also failed to respond to this complaint.

The Council has accepted that its senior officer did not take the appropriate action and has proposed to take the following action within two weeks in settlement of the complaint

- (a) An apology will be provided to Mr X for not responding to his correspondence and complaint
- (b) The Council will make a payment of £50 to Mr X in recognition of the time and trouble taken to make the complaint
- (c) The Council will respond to Mr X’s complaint under separate cover
- (d) The senior officer will be reminded of the Council’s requirements under its complaints procedure

#### Cardiff Council - Refuse collection, recycling and waste disposal

Case Number: 201806596– Report published in February 2019

Mrs X complained to the Ombudsman about repeated failures by Cardiff Council to collect her recycling through a priority assistance scheme. This was despite a number of complaints by Mrs X and repeated assurances that measures were in place to avoid her collections being missed.

Following contact with the Ombudsman, the Council agreed by way of a settlement, to provide Mrs X with:

- A full apology for, and explanation about, why her collections were missed.

The Council also agreed to provide Mrs X with redress of £50 because she had had to repeatedly contact the Council about this matter.

The Council also agreed to implement a number of additional operational and administrative measures with effect from 21 February 2019 to seek to ensure that Mrs X’s recycling is not missed in future. The Ombudsman considered this to be an appropriate resolution of the matter.

## Housing

### Not Upheld

Wrexham County Borough Council - Repairs and maintenance (inc dampness/improvements and alterations eg central heating, double glazing)

Case Number: 201706892 – Report published in March 2019

Ms X complained that there was an unnecessary delay by Wrexham County Borough Council (“the Council”) in carrying out adaptations to their home for her partner, Mr A, following an accident which led to him suffering a spinal injury and becoming wheelchair bound. As a result, Ms X said that Mr A was left housebound for over 18 months.

The Ombudsman was satisfied that the Council had complied with its Housing Strategy in considering whether adaptation works to Mr A's property were necessary and appropriate. It was initially determined that Mr A's property was not suitable for adaptation given his condition at the time, and an offer of a fully adapted property in the same area was discussed with Mr A and Ms X, in line with its Housing Strategy.

When Mr A's condition improved, relevant Council staff exercised their professional judgement in concluding that, as Mr A's mobility had improved and had the potential to improve further, consideration was given to the necessary long-term adaptations to the property. Whilst the Ombudsman acknowledged the frustration that it must have caused Mr A and Ms X, he did not consider that the Council could be held accountable for Mr A being housebound over the period of time as he cannot question the merits of an appropriately taken decision in the exercise of the Council's discretion. Therefore, on the evidence considered, there were no grounds for the Ombudsman to be critical of the Council. The Council's decisions were ones it was entitled to reach in line with its Housing Strategy. The complaint was not upheld.

### Early Resolution and Voluntary Settlement

Wrexham County Borough Council - Right to Buy

Case Number: 201805440– Report issued in January 2019

Mr L complained that the Council had failed to inform him in July 2015 of the reduction in the maximum discount (from £16,00 to £8,00) it was permitted to offer him when purchasing his home under the Right to Buy scheme (“RTB”).

The Council said that it had only been informed of the impending change seven days before its implementation. Therefore, there was a very narrow window for the Council to write to the tenants to which the RTB scheme applied to inform them of the change prior to its implementation. However, the Council subsequently failed to inform tenants of the reduction in discount at all, which is a statutory requirement.

Given that there was no evidence to suggest that Mr L would have been in a position to pursue a RTB application had the Council informed him of the change at the time, the Ombudsman found that any resultant injustice was limited to a loss of opportunity to consider making an application. This being the case, the Council agreed to complete the following actions by 22 February 2019 in settlement of Mr L's complaint:

- a) Apologise to Mr L that he was not informed of the change to the maximum discount permitted by Welsh Government
- b) Offer Mr L a payment of £100 for failing to inform him of the change, which meant that he potentially did not have the opportunity to apply for the maximum discount.

City and County of Swansea - Repairs and maintenance (inc dampness/improvements and alterations eg central heating, double glazing)

Case Number: 201805472– Report issued in January 2019

Mr H complained about the length of time taken by the Council to complete repair works to a leak in a neighbouring property which he said was causing damage in his property.

The Council confirmed to the Ombudsman that the works had been completed. The Ombudsman found that the Council had failed to apologise to Mr H for the length of time taken to complete the repairs, nor had it clarified a comment it had made to Mr H in its complaint response about taking civil action against the Council's tenant.

The Council therefore agreed to address both these matters by 4 February 2019.

City and County of Swansea - Other

Case Number: 201805066– Report issued in January 2019

Mr X is a tenant at a sheltered housing complex. He complained that when he took on the tenancy in March 2018, Council Officers had told him that his 'rent' would be covered by his Universal Credit payments made direct to the Council. He said they had not explained clearly to him that elements of his rent in respect of water and heating would not be covered. As such, he would retain responsibility for paying them direct to the Council. Consequently, he did not make any payments for water and heating.

Although the Council made efforts to explain the position to him and agree a plan for clearing the arrears, Mr X continued not to pay and his arrears continued to accumulate. The Ombudsman could not determine what Mr X had been told by a Council Officer when he signed his tenancy, but the tenancy document included a clear breakdown of the charges that made up the rent. The Ombudsman could not conclude that Mr X had been misadvised, but considered that the Council could consider whether clearer written information could be provided to tenants on what Universal Credit payments would cover.

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

- a) To write to Mr X and apologise for any initial confusion about the rent that may have arisen at the meeting when he signed the tenancy agreement and for not addressing this previously; and,
- b) To consider what amendments could be made to the Council's tenant documentation to make clear what elements of the rent were covered by Universal Credit payments, and what tenants are liable to pay directly to the Council.

Cardiff Council – Other

Case Number: 201804931 – Report issued in January 2019

Mr A (a landlord) complained about the Council's actions including the advice he said it gave him regarding the validity of a legal notice he had issued to his tenant, who was in rent arrears. He claimed that the Council was responsible for his tenant's increasing arrears and wanted it to compensate him. Mr A also complained to the Ombudsman about how the Council had handled his complaint.

The Ombudsman noted that interpreting the legal validity of notices was not a matter for him. He was also satisfied that Mr A had a remedy reasonably available to him to pursue any claim for compensation he considered was owed, as determining claims of compensation was not his primary function. With respect to the Council's handling of Mr A's complaint, the Ombudsman noted that its complaint response to Mr A contained a number of errors, constituting administrative failings. Additionally, the actions the Council had said (9 months earlier) that it would take to address one aspect (by way of staff training) had not happened. In resolution of these concerns, the Council agreed to implement the following actions proposed by the Ombudsman

- (a) To provide Mr A with a written apology for the errors identified as administrative failings in the handling of his complaint (within one month)
- (b) To undertake the staff training identified (within two months)

City and County of Swansea - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number: 201805526 – Report published in February 2019

Mr X complained about the Council's handling of his concerns regarding the standard of work carried out at his home by its contractors. The Ombudsman found that both Mr X and the Council wanted to address the concerns, and both were happy for a visit to be carried out to assess the standard of the work.

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

- a) Arrange a meeting at the property within 2 weeks of the date of our decision
- b) Following from the meeting, issue a further written response, under the second stage of its complaint's procedure, within one month.

Cartrefi Conwy - other

Case Number: 201805693 – Report published in February 2019

The complaint concerned the decision of Cartrefi Conwy ("the Housing Association") to install an electric boiler. The complainant said that, as a result of this decision, she had not been able to run the heating and hot water system because the costs were too high. In order to resolve the complaint, the complainant said that the Housing Association should remove the electric boiler and replace it with a more affordable system.

The Ombudsman said that it was a decision the Housing Association was entitled to reach to install a new electric boiler. However, the Housing Association had not provided any information to the complainant about the heating costs before she had moved in, nor had it visited her or carried out any independent assessment of the costs. The Housing Association had also not carried out any due diligence of the figures provided on the running costs of the system prior to installation.

As the above actions would have amounted to good practice, the Housing Association offered to undertake the following actions in settlement of the complaint: -

- (a) Arrange for an independent engineer to check the electric usage and costs and compare this with the cost of an oil or LPG system.
- (b) Offer the complainant £500 in recognition of her time and trouble in pursuing the complaint and so that she could continue using the system
- (c) Replace the heating system at the property, if the outcome of the independent engineer's assessment of the usage and costs of the current system is that this is in the complainant's best interests.

The Ombudsman considered this to be a reasonable settlement of the complaint.

Charter Housing Association (Part of the Pobl Group) - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number: 201807092 – Report published in March 2019

Mr J complained that a kitchen that was installed for him by Charter Housing Association ("the Association") was not fully accessible to him due to his disability.

The Association has agreed to make any modifications that may be recommended following a further occupational therapy ("OT") assessment.



Mr J will need to arrange a new OT assessment.

#### [Cartrefi Cymunedol Gwynedd - Neighbour disputes and anti-social behaviour](#)

[Case Number: 201807762 – Report published in March 2019](#)

A boundary hedge had been removed by a neighbouring tenant of the Association without Ms K's consent. A fence that was erected by the Association in its place is too low and causing privacy concerns. Citizens Advice ("CAB") acted as an advocate on Ms K's behalf to make her complaint, however, the association did not respond to the letter or log the matter as a complaint.

The Association has agreed to undertake the following in resolution of the complaint:

- a) By 3 April 2019, apologise to Ms K for not responding to the CAB complaint letter.
- b) By 12 June 2019, investigate and respond to Ms K's complaint.

#### [Wrexham County Borough Council - Estate management and environment/common areas/hedges and fences etc](#)

[Case Number: 201806737 - Report published in March 2019](#)

Mr & Mrs X complained that the Council failed to deal appropriately with a fencing issue at the side of their property.

The Ombudsman found that the Council had failed to undertake all of the actions it had previously agreed to. The Council therefore agreed to complete the following in settlement of Mr & Mrs X's complaint by 8 April 2019:

- a) Provide an apology for the delay in implementing the agreed actions
- b) Undertake any necessary works in relation to the overgrown hedge that is bordering the property
- c) Remove the brambles and fill the gap in the fence that this will create.

## NHS Independent Provider

### **Not Upheld**

[Abermad Private Nursing Home - Care homes](#)

[Case Number: 201800404– Report published in February 2019](#)

Ms D complained about the standard of care provided to her late mother, Mrs M, by a Nurse at her Care Home ("the Home") in February 2018. She also complained about the Home's response to her complaint, and that her mother was given notice to quit the Home in response to Ms D's complaint.

The Ombudsman did not uphold the complaints. He found that the actions taken by the Nurse were appropriate, as was the Home's response to Ms D's complaint. He also did not uphold the complaint about Mrs M being given notice to quit, as it was clear that there had been no maladministration in how the Home reached its decision.

## Planning and Building Control

### **Upheld**

[Flintshire County Council - Unauthorised development - calls for enforcement action etc](#)

## Case Number: 201706403– Report issued in January 2019

Mrs B complained to Flintshire County Council (“the Council”) about the way it handled an application to amend planning permission for a house to be built on the plot of land next to her house. Mrs B said that the amended plans resulted in significant changes to the proposed neighbouring property which have had a significant impact on her privacy and amenity.

The Ombudsman found that the consultation on the application was flawed as it failed to adequately describe the development or include site plans which would show the intention of the applicant to move the location of the house on the plot. The Ombudsman found that the Case Officer failed to adequately consider the impact that the relocation of the house would have on the amenity of Mrs B’s property. The Ombudsman also found that the Council did not act in accordance with its Enforcement policy in respect of this case and that it failed to handle Mrs B’s complaint properly.

Since the events, the Council has made a significant number of improvements to both its planning and enforcement processes. The Council agreed to apologise for the failings identified in the report, to engage the district valuer to assess the impact the relocation of House A had on the amenity of Mrs B’s property and make a payment equivalent to the devaluation which resulted from this change and to meet with Mrs B to establish whether there are any outstanding enforcement matters.

## Powys County Council - Handling of planning application (other)

### Case Number: 201702480 – Report published in February 2019

Mrs A complained that the Council’s refusal to take enforcement action in relation to a window at a listed building (“House Y”) near her home was based on a misunderstanding of planning law. Mrs A said that the window overlooked her study, was uncharacteristic of the rest of the House Y and was of poor quality.

In response to the complaint, the Council explained that, in 2016, planning and listed building consent applications had been submitted to the Council by the owner of House Y and that the disputed window had been included on the drawings submitted with these applications; therefore, the approval of these applications had regularised the window and that it could not take planning enforcement action. The Council also said that it was not expedient for it to take listed building enforcement action, as it did not consider the window to have an unacceptable impact on the architectural and historical significance of House Y.

The investigation found that, whilst the window was included on the drawings of the planning and listed building 2016 applications, they did not include a request for permission for the disputed window and indicated that the proposal involved “no windows”. The Ombudsman commented that it was a well-established principle of planning law that a Council can only grant permission in accordance with the terms of an application and that, as the window was not included in the 2016 planning application, it has not gained permission from the Council’s decision to grant that application. The Ombudsman considered that there was no reason why this should not be the case regarding listed building consent applications as well.

Accordingly, the Ombudsman concluded that the Council’s decision, that the window had been regularised as it had been included on the drawings with the 2016 planning applications, was an incorrect interpretation of planning law and that this amounted to maladministration.

As the Ombudsman was satisfied that the window at House Y remained unauthorised from both a planning and listed building consent perspective, he also concluded that, due to new evidence regarding the window submitted to the Council since 2016, a fresh assessment of whether listed building enforcement action was appropriate could have been undertaken. The Ombudsman found that this amounted to maladministration.

The Ombudsman recommended that the Council apologises to Mrs A and provides her with a redress

payment of £750 in total to account for the delay and distress she had experienced throughout the handling of her enforcement request and complaint. Also, that the Council reconsiders whether to take listed building enforcement action in relation to the disputed window and informs Mrs A of the reasons for its decision.

## Swansea Council – Other planning matters

Case number: 201707556 – Report issued in March 2019

Mr K complained that the City and County of Swansea (“the Council”) failed to take timely and appropriate action regarding waste he said was illegally dumped by a local developer (“the Developer”) at the rear of his property.

The Ombudsman's investigation found that in 2014 and 2015 the Council took appropriate action to clarify ownership of the land at the rear of Mr K's property in order to address the waste that had been dumped. However, the Developer challenged the Council and the matter was passed to its Legal department. Unfortunately, the Council took no further action during 2016 until a solicitor's letter on behalf of Mr K and his neighbours prompted the Council to act. The Council obtained statements in July 2017 from Mr K and his neighbours and took further legal advice to support its potential legal action against the Developer. However, the advice said that the statements were inconclusive, and it was not proportional to take action having due regard to all the evidence available to the Council. The Ombudsman discovered that this information was not given to Mr K and he was only made aware of it following the Ombudsman's investigation.

The Ombudsman concluded that whilst the Council's decision to not take action against the Developer was a properly made decision it was entitled to take, it had failed to communicate appropriately with Mr K in 2016 and following the legal advice it received in July 2017. In terms of the delay and the injustice this caused Mr K, the Ombudsman upheld the complaint.

The Ombudsman recommended that the Council apologise to Mr K, pay financial redress to Mr K, and arrange a meeting with Mr K and his neighbours to discuss its decision and ongoing matters with the Developer.

## Not Upheld

Powys County Council - Handling of planning application (other)

Case Number: 201800545 – Report issued in January 2019

Mr and Mrs C, Mrs H and Mrs X (“the Complainants”) complained about Powys County Council (“the Council”) and its decision to approve a neighbour's outline planning application. The Complainants said that the Council failed to be open and transparent about how it reached its decision. In particular, the Complainants were unhappy that the Council failed to publicise the planning application correctly and failed to follow relevant guidance in consideration of the proposed rural enterprise dwelling.

The Ombudsman found that the Council fulfilled its legislative responsibilities by publicising the planning application with a site notice on the boundary of the property. The investigation also found that the Council followed the relevant Welsh Government guidance when it considered the application. A rural enterprise dwelling application requires specialist input from Chartered Surveyors and Accountants, and the Ombudsman was satisfied that the Council considered and satisfied itself that the application met the tests set out in the relevant guidance.

The Ombudsman did not uphold the complaint.

## Early Resolution and Voluntary Settlement

Flintshire County Council - Handling of planning application (failure to notify those affected)

Case Number: 201804365 – Report issued in January 2019

Mrs C complained that the Council had failed to notify her and allow her an opportunity to take part in the

consultation regarding a planning application for a garage near her home.

She also complained about the delays by the Council in responding to her complaints.

The Ombudsman decided that there were no grounds for investigation by his office. He approached the Council regarding the delays in its complaint responses.

The Council agreed to:

- 1) Write a letter of apology to the complainant for the delays in responding to her complaint
- 2) Offer her a payment of £100 for the time and trouble taken to pursue her complaint.  
This would be completed within 20 working days of my decision letter.

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

### [Cardiff Council – Other planning matters](#)

[Case number: 201807028 – Report issued in March 2019](#)

Mrs X complained that, before purchasing her property, the Council agreed that the land attached to it would be transferred into her name but that the transfer had been significantly delayed. Mrs X said that the delay has led to her incurring additional costs.

The Ombudsman found that although Mrs X raised her concerns, the Council failed to recognise her correspondence as a formal complaint.

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

- (a) Provide Mrs X with an apology for the delay in considering her complaint
- (b) Provide Mrs X with a Stage 2 investigation response within one month of the date of our decision.

### [Rhondda Cynon Taf County Borough Council - Unauthorised development - calls for enforcement action etc](#)

[Case number: 201805932 – Report issued in March 2019](#)

Ms A complained about the Council's decision not to take enforcement action for an unauthorised development and a failure to comply with planning conditions by her neighbour. Following assessment of the evidence presented it was decided not to investigate Ms A's complaint. Enforcement action is a discretionary decision and there was no evidence to show the decisions reached by the Council were not properly taken, and no evidence that the Council had acted contrary to written policy, procedure, guidance or legislation.

Although it was decided not to investigate Ms A's complaint, based on the information seen, the Ombudsman considered that there was an opportunity for the Council to progress matters about the neighbour's delay in providing it with sufficient information to evidence compliance with planning conditions. The Council voluntarily issued a letter to the neighbour specifically asking for the required information by a certain date.

The Council has now agreed that if the required information is not provided by the neighbour by the specified date, it will again consider whether enforcement action for breach of planning conditions would be expedient.

## Roads and Transport

### **Early Resolution and Voluntary Settlement**

Conwy County Borough Council - Other

Case Number: 201804848 – Report issued in January 2019

Ms C complained that the Council had failed to deal with refuse bins and inconsiderate parking by neighbours that caused an obstruction and prevented vehicular access to a lane at the rear of her property.

The Ombudsman found that the Council appeared to have responded to the complainant at stage 1 of its complaints procedure and was of the view that it needed to respond further. He contacted the Council. It has agreed to:

- a) Provide the complainant with a written response to her complaint at stage 2 of its procedure.

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

The Ombudsman is satisfied that the action taken by the Council provides a resolution to this complaint.

Cardiff Council – Other

Case number: 201806478– Report issued in March 2019

Mr X complained that the Council failed to provide updates following a request he made for two road signs to be replaced. Mr X also complained that it has been over a year since he raised his request and the Council have failed to replace the signs.

The Ombudsman found that the Council had failed to update Mr X during the course of its investigation and the road signs have not been replaced. The Council agreed to complete the following in settlement of Mr X's complaint:

By 20 March 2019:

- a) Issue a complaint response
- b) Provide an explanation as to why no response had been issued and the reasons for the delay in replacing the road signs

As soon as reasonably practicable:

- c) Replace the two road signs.

## **Self-funding Care Provider**

**Upheld**

Hafod Care Association Limited – Care Homes

Case number: 201803867 – Report issued in March 2019

Ms X complains that a care home ("the Care Home") run by Hafod Care Association Ltd failed to protect her mother, Mrs Y, from harm and failed to provide adequate explanation for what happened when her thigh was scalded.

The Ombudsman found that although Ms X was given differing accounts of what had happened, this was most likely due to different recollections from different staff rather than anything sinister. However, the Ombudsman found that, when it produced a pressure care support plan for her, the Care Home failed to

consider the risk to Mrs Y from eating and drinking in bed. This resulted in her being left with a hot drink which was difficult for her to use and a large scald to her left thigh. The Ombudsman recommended that the Care Home should apologise to Mrs Y's family and consider what action it needs to take to ensure its staff consider all the risks before updating support plans.

## **Ty Pentwyn Nursing and Residential Home - Care Homes** **Case number: 201801210 – Report issued in March 2019**

Mr B complained about the care and treatment his father Mr C received at Ty Pentwyn Nursing and Residential Home ("the Home"). He said the Home failed to make adequate provision for Mr C's end of life care which resulted in an inappropriate admission to hospital, that the Home did not treat Mr C with dignity and respect by failing to adequately dress him for the transfer to hospital causing considerable distress to his family, and that the Home failed to properly advise Mr B how to progress his complaint.

The Ombudsman found that the decision to call an ambulance for Mr C was finely balanced but was reasonable as Mr C was in distress and it was the Nurse's professional duty to take the most appropriate action to relieve the distress to the person in her care. The Ombudsman did not uphold this element of the complaint. However, he found that there was no evidence to suggest the Nurse had considered Mr C's dignity when preparing him for transfer to the hospital and that the Home had not properly advised Mr B how he could pursue his complaint. The Ombudsman upheld these elements of the complaint.

The Home agreed to apologise to Mr C's family for the failings identified, to remind staff of the importance of maintaining patient dignity and to update the complaint policy to accurately reflect the process.

## **Social Services – Adult**

### **Upheld**

**Abertawe Bro Morgannwg University Health Board - Services for vulnerable adults (eg with learning difficulties. or with mental health issues)**

**Case Number: 201800102 – Report published in March 2019**

A solicitor complained, on behalf of Ms E, about the delivery of services for Ms E under a Care and Treatment Plan, in particular, about failings in the Health Board's planning for, and handling of, her move from her parents' home into her own home in the community. He also complained about the Health Board's failure to deliver the support included in Ms E's Plan, her discharge from the psychology service and the handling by the Health Board of the complaint made on her behalf.

The Ombudsman partly upheld the complaint. He found that the Health Board had not followed commissioning processes for the identification and acquisition of a property for Ms E, and had failed to put in place any contingency plan in the event that the identified property did not become available. The Ombudsman did not uphold the elements of the complaint relating to delivery of support or discharge from the psychology service.

The Health Board had already recognised failings in its handling of the complaint and offered redress for this. The Ombudsman recommended financial redress for the distress caused by the failings he identified, and a review of compliance with commissioning procedures in the Learning Disability Service.

### **Early Resolution and Voluntary Settlement**

**Rhondda Cynon Taf County Borough Council - Services for older people**

**Case Number: 201804370– Report issued in January 2019**

Mr A complained that the Council had acted with maladministration in relation to the service provided to

his father-in-law, the late Mr C, by the adult social services team. The Council had commissioned an independent review in relation to social services' involvement with Mr C's care, and had provided a letter summarising the outcome of the review to Mr A and his wife.

Although the Ombudsman declined to investigate Mr A's complaint, he was concerned that the letter sent to Mr and Mrs A did not contain all of the information which it would have been appropriate to provide.

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

- (a) To apologise to Mr and Mrs A for failing to address one of the recommendations contained within the independent review in the letter sent to them, and to address that recommendation;
- (b) To disclose to Mr and Mrs A the full independent review (redacted as necessary);
- (c) To apologise to Mr and Mrs A in line with the independent review;
- (d) To provide an update to Mr and Mrs A in relation to recommendations where further steps were to be taken.

#### [Wrexham County Borough Council - Services for People with a disability inc DF](#)

[Case Number: 201805677 – Report issued in January 2019](#)

Mrs Y complained on behalf of Miss X that an action agreed in December 2017 following a stage 2 Social Services complaint to Wrexham Council (specifically to arrange an independent assessment) had not been carried out.

The Council had approached Flintshire Council to carry out the independent assessment as part of a reciprocal agreement with them. However, as yet, this has not happened due to resource issues. The Council therefore agreed that:

- It would contact Flintshire Council again about the initial assessment;
- If Flintshire Council were unable to carry out the initial assessment by 31 March 2019, Wrexham Council would commission and fund a suitable independent agency to carry out the initial assessment.

#### [Gwynedd Council - other](#)

[Case Number: 201806511 – Report published in February 2019](#)

Ms X complained that her social worker failed to implement early intervention and preventative care following her mental health crisis. Ms X explained that despite having several home visits and experiencing several crisis, the social worker failed to put a care or crisis plan into action and refer her to a psychologist.

The Ombudsman found that although Ms X raised her concerns under Stage 1 of the complaint process, the Council failed to inform her of the Stage 2 independent review.

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

- a) Provide Ms X with a stage 2 investigation response within one month of the date of our decision.

#### [Newport City Council - Services for older people](#)

[Case Number: 201806827 – Report published in February 2019](#)

Mr R complained that the Council had failed to lift restrictions placed upon him visiting his late mother when she resided in a care home. He complained of other issues regarding the same subject.

The Ombudsman believed that Mr R had sought an alternative legal remedy which placed it outside his

jurisdiction. Mr R provided information to show that he was not seeking an alternative legal remedy. In view of this the Ombudsman contacted the Council and it agreed to:

- 1) Provide Mr R (via his advocate) with a Stage 2 complaint response to each of the five issues raised in his current complaint.

This should be completed within the next 30 working days from the date of this decision letter.

The Ombudsman believes that this will resolve his complaint at this stage.

## [Cardiff Council - Services for older people](#)

[Case Number: 201807115 – Report published in February 2019](#)

Ms S complained that the Council had failed to undertake an assessment of needs for her father.

Ms S also complained that the Council had not responded to her complaint made to it in November 2018.

The Council has agreed to undertake the following in resolution of Ms S's complaint:

- a) Provide Ms S with a full written response by 12 March 2019.
- b) Undertake an assessment of needs for Ms S's father by 23 April 2019.

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

[Case Number: 201804175– Report published in February 2019](#)

Mr A complained that the Isle of Anglesey County Council ("the Council") refused to escalate his concerns, relating to the actions of Social Services care worker who were providing daily living support services to his late brother, to an independent investigation pursuant to Stage 2 of the Social Services Complaints Regulations 2004.

Following the commencement of an investigation by the Ombudsman the Council proposed a voluntary settlement of Mr A's complaints.

The Council agreed to:

1. Arrange for Mr A's complaint to be investigated under Stage 2 of the Social Services Complaints Procedure.
2. To offer Mr A the opportunity to clarify any additional complaint points which he wishes to be considered about actions by either the Council or the advocacy service commissioned by it at the relevant time to provide services to his late brother.
3. Offer to commission the support of an appropriate independent professional advocate to assist Mr A with making and clarifying his complaint to the Council.

The investigation was discontinued on this basis.

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

[Case Number: 201805695 – Report published in February 2019](#)

Mr & Mrs A complained that the Council's Adult Social Care team had failed in its delivery of support provision for their adult son B. After a solicitor had written to complain on their behalf, Mr & Mrs A said that there was a delay in both acknowledging and responding to that complaint. Subsequently, having requested that the matter progress to a Stage 2 investigation under the relevant provisions ("the Regulations"), Mr & Mrs A said that nothing had happened, and a number of weeks had passed.



Whilst declining (for jurisdictional reasons) to investigate the substantive complaint about support provision, the Ombudsman felt that there had been a failure to deal with Mr & Mrs A's subsequent complaint, and a failure to provide them with statutory information as prescribed by the Regulations. After approaching the Council, it agreed with the Ombudsman's proposal to resolve the complaint by undertaking the following actions:

- a) To apologise in writing to Mr & Mrs A for the complaint handling failures (in 14 days)
- b) To immediately progress the substantive complaint about care/support provision for B to Stage 2 (appointing an Independent Investigator within 14 days)
- c) The authority's Director of Social Services to satisfy himself that the way in which complaints are handled pursuant to the Regulations are in accordance with that process, and that key statutory information is provided to complainants, amending any template letters as required (within one month)
- d) A reminder to be issued to complaint handling staff regarding the statutory requirements for dealing with complaints about social care matters (within one month).

## [Bridgend County Borough Council - Services for older people](#) [Case Number: 201806483 – Report published in March 2019](#)

Mrs X complained about the care her aunt had received during a period of respite care at a residential home. The Council had responded to her complaint under Stage 1 of the statutory Social Services complaints procedure but had declined to progress the matter to Stage 2, due to the limited care records held by the residential home.

The Ombudsman asked the Council to apologise for declining to progress Mrs X's complaint and to promptly make arrangements for her complaint to be considered under Stage 2. The Council agreed to do so.

## Social Services – Children

### **Early Resolution and Voluntary Settlement**

#### [Powys County Council – Children in care/taken into care/'at risk' register/child abuse/custody of children](#) [Case Number 201807055 – Report published in March 2019](#)

Ms A complained that a social worker had failed to safeguard her family from a case of manipulation and had not taken advice from relevant third parties in assessing her case.

The Ombudsman previously referred Ms A's complaint to the Council for consideration in accordance with The Social Services Complaints Procedure (Wales) Regulations 2014 ("the Regulations").

The Ombudsman found that the Council had made reasonable attempts to engage with Ms A in order to investigate her concerns.

The Council agreed to complete the following actions in settlement of Ms A's complaint:

#### **By 26 March 2019:**

- a) Write to Ms A with a full written record of the complaint and ask for her to comment on its accuracy.

#### **Within 15 working days of writing to Ms A:**

- b) If the Council does not hear from Ms A, to progress with its Stage 2 Formal Investigation and issue a response within 25 working days, in accordance with the Regulations.

## Various Other

### Upheld

Cafcass Cymru - Other miscellaneous

Case Number: 201802041 – Report issued in January 2019

Ms X complained about the way Cafcass Cymru investigated and handled her complaint.

The investigation found that, in so far as reasonably possible, Cafcass Cymru acted in accordance with its own internal policy and procedure during its investigation into Ms X's concerns and the manner in which it handled her complaint.

The investigation found that the Information Commissioner's Office ("ICO") was the most appropriate organisation to determine whether Cafcass Cymru's actions amounted to a breach of the Data Protection Act ("DPA"). The ICO concluded that it is unlikely that Cafcass Cymru complied with the requirements of the DPA. Cafcass Cymru accepted the decision of the ICO. The investigation found that this breach represented an injustice to Ms X and so the complaint was partially upheld in relation to this specific issue. The ICO required Cafcass Cymru to apologise to Ms X, undertake remedial action and to revise its policies. The ICO was overseeing the revision of the amended policies and the implementation of remedial action. In addition, Cafcass Cymru had apologised to Ms X for the way it handled her personal information. There was nothing further that could be recommended to assist Ms X.

GUILSFIELD COMMUNITY COUNCIL - Poor/No communication or failure to provide information

Case Number: 201800388 – Report published in March 2019

Mr and Mrs C, Mr and Mrs D, Mrs X and Mr E ("the Complainants") complained about the overall actions and decisions of GUILSFIELD COMMUNITY COUNCIL ("the Council") from October 2017 onwards, and its communications with each of them. In particular, the Complainants said the Council failed to respond to questions regarding the Council's decision to support a planning application ("the Application"); failed to respond to questions regarding standing orders and a potential conflict of interest, and failed to adequately deal with and respond to the Complainants' individual complaints.

The Ombudsman's investigation found that the Council did not explain clearly to the Complainants why it chose to support the Application. Additionally, the Council also failed to respond to specific questions and did not deal with Complainants' individual complaints. In particular, a letter from the Chair to the Complainants exacerbated the situation by not addressing the Complainants' concerns and being critical of their overall behaviour. The Ombudsman also found that the Council had not adopted the Model Concerns and Complaints Policy and Guidance published by Welsh Government, which resulted in the complaints being dealt with in an incoherent fashion.

The Ombudsman upheld the complaint and recommended that the Council apologise to the Complainants, and at its next meeting consider adopting the Model Concerns and Complaints Policy and Guidance. The Ombudsman also suggested that the Council ensure up-to-date approved minutes are available on its website.

### Early Resolution or Voluntary Settlement

Betsi Cadwaladr University Health Board - Poor/No communication or failure to provide information

Case Number: 201806569 – Report published in February 2019

Mr A complained that the Health Board had placed a 12-month contact restriction on him without allowing him to appeal the restriction. Mr A also complained that the Health Board had failed to contact him regarding genetic testing.

The Ombudsman found that the Health Board's procedure for managing contact incorrectly referred a person to whom a contact restriction may apply to appeal to his office. The Ombudsman would not perform an appellate function in such matters.

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

**Within 4 weeks:**

- a) Apologise to Mr A that the letter addressed to him was not issued in line with the procedure
- b) Write to Mr A to outline its position regarding genetic testing.

**Within 6 weeks:**

- c) Reword the procedure to correct the error referring a person to the Ombudsman to make an appeal about contact restrictions.

**Within 10 weeks:**

- d) Consider and respond to Mr A's complaint to the Ombudsman as an appeal, in line with the reworded procedure.

[Monmouth Town Council - Poor/No communication or failure to provide information](#)

Case Number: 201807174 – Report published in March 2019

Mr X complained that the Council had not fully responded to his complaint about its alleged failure to invite members of the public back into meetings following private discussion.

Whilst the Council had provided its rationale for excluding the public from certain agenda items to Mr X, the Ombudsman found that it had not fully responded to his complaint that members of the public were not subsequently invited back into meetings.

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

- a) Apologise to Mr X for failing to fully respond to his complaint
- b) Respond to Mr X's complaint about the public not being invited back into meetings
- c) Respond to any of Mr X's concerns which remain outstanding and which the Council considers it had not had the opportunity to fully respond to.