

The Ombudsman's Casebook

Issue 38 July – September 2019

News

Consultation is now closed

Stakeholder consultation is now closed on the principles and procedures relating to the new powers created by the Public Services Ombudsman (Wales) Act 2019.

The Ombudsman alerted participants to the consultation through a series of seminars and presentations organised by Ombudsman staff. Emails directing organisations to the documents were sent to bodies in the Ombudsman's jurisdiction, members of the Ombudsman's Service Users Sounding Board, third sector organisations, Assembly Members and other Commissioners in Wales.

The Ombudsman wishes to thank all stakeholders for their responses.



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Health

Upheld

[Cwm Taf University Health Board - Clinical treatment in hospital](#)
Case Number: 201706582 – Report issued in July 2019

Mrs X complained that the Health Board failed to provide adequate care for, and appropriately manage, her pregnancy on 14 January 2017, when she was a patient at the Royal Glamorgan Hospital. She was of the view that her unborn baby died because of the poor care she received.

The Health Board accepted that it failed to provide adequate care for, and failed to appropriately manage, Mrs X's pregnancy. It acknowledged that there were no antenatal assessments performed between 9.00am and 10.20pm on 14 January. It said that a full maternal and foetal assessment should have been undertaken every four hours. When Mrs X was attended by midwives, at approximately 10.20pm, they were unable to identify a foetal heartbeat. The unborn baby had sadly died.

The investigation could not conclude that it was likely that the baby had died because of the inadequate care. However, there was significant uncertainty as to whether the outcome might have been different had the service failure identified above not occurred, which was sufficient to cause distress and an injustice to Mrs X. The complaint was, therefore, **upheld**.

The Health Board agreed to apologise to Mrs X for the failings in her care and to offer £1000 for the distress caused.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#)
Case Number: 201802363 – Report issued in July 2019

Mrs C complained about the care and treatment provided to her adult son, Mr B, by the Health Board's mental health services. Mrs C complained of a lack of a proper needs assessment and failure to take into account Mr B's family's concerns, that Mr B was given unaccompanied leave from which he absconded, that Mr B was not given access to appropriate support, discharge arrangements were made without an appropriate plan in place, that when Mr B was finally discharged he was not referred or signposted to appropriate services and a consultant did not give appropriate advice when Mr B was not compliant at taking medication. Mrs C also complained about delays in the complaint handling.

The investigation found that the overall standard of care was reasonable, Mr B had access to appropriate support and was given the opportunity to have input into his care and treatment plan. During Mr B's stay as an inpatient there was a failed discharge attempt and the plan for that discharge was not sufficient. The Ombudsman therefore upheld that element of the complaint. Whilst this caused distress to Mr B and Mrs C, it did not impact on Mr B's overall care and he remained an inpatient for one more month before he was discharged. The investigation found that on that occasion the discharge plan was appropriate. Mr B was signposted to appropriate support services, but it was a matter for him whether he decided to engage with them or take his medication. The investigation upheld Mrs C's complaint that there were unreasonable delays in the handling of her complaint.

The Health Board agreed that it would, within one month of the date the report was issued, apologise to Mrs C for the confusion around the failed discharge and undertake guided reflection with the staff involved. It also agreed to apologise to Mrs C for the delay in handling her complaint and make a payment of £125 for the inconvenience caused by this delay.

[Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#)
Case Number: 201804791 – Report issued in July 2019

Mr Y complained about the care and treatment provided to him by a locum GP (“the GP”) at a Surgery managed by the Health Board. He considered that the GP failed to properly assess him during a consultation and failed to diagnose that he had pneumonia which was later diagnosed when he was admitted to hospital three days later.

The Ombudsman found that, had the GP’s clinical examination and history-taking been sufficiently thorough, and in line with GMC guidance, then it might have been possible to conclude whether her actions were clinically appropriate. However, the shortcomings in record-keeping meant the Ombudsman was unable to determine with certainty whether the consultation was within the boundaries of acceptable clinical practice, and whether the diagnosis of flu-like symptoms was reasonable, or whether further assessment and history-taking might have resulted in a different diagnosis and earlier treatment. In addition, there was no evidence within the consultation record that safety-netting advice was provided, which was a further shortcoming. This uncertainty amounted to an injustice and the complaint was upheld.

The Health Board agreed to apologise to Mr Y for the identified failing and make a redress payment in recognition of the uncertainty caused by the shortcomings at the consultation.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#)
Case number: 201802377 – Report issued in July 2019

Ms Y complained about her late father (Mr X’s) treatment at Neath Port Talbot Hospital in 2017. Specifically, she complained about her father’s diabetes management, that there was a failure to properly deal with an ulcer on his toe which led to it being amputated, that he was not given his mental health medication for a five day period and that there was a delay in referring him to a Mental Health Liaison Nurse (MHLN).

The Ombudsman found that the management of Mr X’s diabetes was reasonable and, in particular, that changes to his medication were appropriate in the circumstances. He did not uphold this part of the complaint. Mr X was at risk of developing complications with his feet due to his diabetes and dementia. The nursing records for the period in question were missing, so it was not possible to say with any certainty whether the problem with Mr X’s toe ulcer could have been identified sooner and action taken to avoid the amputation. On balance, the Ombudsman upheld this part of the complaint. The Ombudsman noted that the prescription charts showed that mental health medication was given to Mr X on three occasions within the five day period, however, the absence of nursing records meant it was impossible to say whether there were other times the medication should have been given. In view of that uncertainty, he upheld this part of the complaint. Finally, although Mr X would ideally have been seen sooner by the MHLN, in practice this did not cause him any detriment. The Ombudsman did not uphold this part of the complaint.

The Ombudsman recommended that the Health Board apologises to Ms Y, reviews its procedures to ensure that its diabetic specialist teams are alerted to the admission of patients with diabetes, reminds relevant nursing staff of the risks of foot injuries in patients with diabetes and dementia, and informs the Ombudsman and Ms Y of the outcome of a review it was conducting into the transfer of records between hospitals.

[Aneurin Bevan University Health Board & Welsh Ambulance Services NHS Trust - Ambulance Services](#)
Case Number: 201706461 & 201706121 – Report issued in July 2019

Mrs A complained that on 1 January 2017, the Welsh Ambulance Services NHS Trust failed to provide an ambulance for her father, Mr B, within an appropriate timeframe. Mrs A said that the Trust had not prepared for service demand over the New Year period, failed to correctly categorise the emergency calls her family made and did not contact Royal Gwent Hospital (“the Hospital”) to request that ambulances were released for service. Mrs A also complained that the treatment provided by the ambulance crews who attended Mr B was inappropriate. In relation to Aneurin Bevan University Health Board, Mrs A complained that it failed to adhere to its escalation policies and release ambulances from the Hospital for service in a timely manner. Finally, Mrs A complained that the handling of her complaint by the Trust and the Health Board was poor.

The Ombudsman found that both the Trust and Health Board had appropriate plans in place for the New Year period and implemented them, but the increase in calls that day (nearly 95% higher than the same day the previous year) could not realistically have been predicted. He did not uphold this part of the complaint. There were errors in categorising some of the calls, but this did not affect how long it took for an ambulance to attend. To the limited extent that there was uncertainty that the outcome could have been different had the time taken to respond once the call was categorised as “Red” been shorter, the Ombudsman upheld this part of the complaint against the Trust. The Ombudsman found that the care provided by the paramedics when they arrived was appropriate. He did not uphold this part of the complaint. The Ombudsman found there were some failings in how Mrs A’s complaints were handled by the Trust and the Health Board and he upheld those parts of the complaint.

The Ombudsman recommended the bodies apologise to Mrs A for the failings identified and that the Trust and Health Board pay her £250 and £100 respectively for the complaint handling errors. The Ombudsman also recommended that the Trust provide him with evidence that it had implemented the improvements it had already decided to make as a result of Mrs A’s complain

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#)
Case Number: 201804041 – Report issued in July 2019

This complaint related to care provided by Abertawe Bro Morgannwg University Health Board which, since the time of the events, has been renamed Swansea Bay University Health Board. Consequently, this report is now addressed to the Swansea Bay University Health Board to take forward any matters commented upon and its recommendations.

Mrs B complained that, while her father (“Mr C”) was admitted to hospital between 3 and 7 October 2017 with a gastric blockage caused by terminal stomach cancer, the Health Board failed to monitor his condition appropriately, take reasonable action to manage his vomiting, toileting and hygiene needs or give him appropriate treatment. Mrs B also complained that neither Mr C nor his family were kept informed about Mr C’s condition or prognosis, and that the Health Board failed to process her complaint appropriately.

The Ombudsman found that there was no evidence the Health Board adequately explained Mr C's condition, his prognosis or his deterioration. Therefore, the family were unprepared for his deterioration and death. He also found that there was inadequate monitoring of Mr C's vomiting, toileting and hygiene needs although the Health Board had already acknowledged this shortcoming and taken appropriate steps to monitor and improve nursing standards. The Ombudsman also found that there was a delay in seeking specialist advice on how best to manage Mr C's symptoms, however the nature of his condition meant that an earlier referral would not have changed the treatment he received, or the eventual outcome. Finally, the Ombudsman found that although the substance of Mrs B's complaint was complex, the final response was issued beyond the extended statutory time frame of six months. Furthermore, the Health Board failed to manage Mrs B's expectations throughout the process.

The Health Board had already offered apologies for the shortcomings identified, and therefore the Ombudsman did not make any recommendation for an apology. However, he recommended that the Health Board should offer Mrs B token sums of money in recognition of the failures to manage her expectations and to communicate effectively with Mr C and his family. He also recommended that the Health Board should remind relevant staff of the importance of providing meaningful updates, keeping patients and their families informed, and of the required standards of nursing care.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#)
Case Number: 201800160 – Report issued in July 2019

Ms T complained about the care given to her late mother, Mrs Y, by Aneurin Bevan University Health Board. Her complaint concerned the Health Board's management of Mrs Y's suspected bowel obstruction, stomach and bowel-related bleeding and end of life care. Ms T raised, in relation to Mrs Y's suspected bowel obstruction, concerns about the timeliness of Mrs Y's care, Mrs Y's transfer between hospitals, the completion of a water-soluble contrast enema ("the contrast enema") and the insertion of a colonic stent ("the stent"). Ms T also expressed concern about the Health Board's complaint handling.

The Ombudsman found that the Health Board had not managed Mrs Y's hospital transfer, in terms of planning and its handling of its apparent radiology resource deficit, properly. He accepted that Mrs Y's clinical care had not been compromised, to a discernible extent, because the Health Board had not completed a contrast enema. Nor did he conclude that not inserting a stent constituted a clinical failing. He partly upheld that aspect of Ms T's complaint, which concerned the management of Mrs Y's suspected bowel obstruction, because the failings identified in relation to transfer planning and resource shortfall management caused Mrs Y a significant injustice in the form of considerable and avoidable distress. He found that those failings also prevented Mrs Y from making an informed choice about her treatment and from deciding sooner that she wished to go home. He partly upheld that element of Ms T's complaint, which concerned the management of Mrs Y's end of life care, because the transfer planning and resource shortfall management-related failings identified caused Mrs Y, in terms of impaired patient choice and dignity, a significant injustice. He did not uphold that part of Ms T's complaint, which concerned the management of Mrs Y's stomach and bowel-related bleeding. He found that the Health Board had not acknowledged or responded to Ms T's concerns about its written response to her complaint. He upheld the complaint handling part of Ms T's complaint because these complaint handling failings caused Ms T, in terms of uncertainty and dissatisfaction, a significant injustice.

The Ombudsman recommended that the Health Board should, within the next four weeks, write to Ms T to apologise for the failings identified. He also recommended that the Health Board should critically review the written complaint response that it had sent to Ms T, prepare a report about that critical review, remind staff that the availability of key and solitary specialists must be checked before hospital transfers, which have been prompted by the prospect of their input, are made and send Ms T a copy of its critical review report and evidence of the formal reminder that it had issued. He asked the Health Board to complete those tasks within the next ten weeks. He also recommended that the Health Board should, within the next six months, give Ms T information about the introduction of its electronic rota system. The Health Board agreed to implement these recommendations.

[Bupa Dental Care Caernarfon - Clinical treatment outside hospital](#)
Case Number: 201803353 – Report issued in July 2019

Ms A complained about the extraction of her upper left molar tooth (UL6) performed by a locum dentist (“the Dentist”) working at the dental practice in question (“the Practice”). The Practice was operating the dental contract for a company (“the Company”) which had entered into arrangements with the local health board to provide NHS dental care. Ms A said she was not given any option other than extraction. She had later been told by another dentist that this may not have been needed. Ms A felt that the Dentist had acted in haste and had not done enough to save her tooth. She had since privately funded a dental implant and was unhappy with how her complaint had been dealt with.

To assist his investigation, the Ombudsman sought advice from one of his professional advisers (“the Adviser”) who examined Ms A’s dental records. The Adviser noted that the clinical records showed no evidence of any discussion with Ms A about other options. In his opinion the UL6 might have been salvaged through root canal treatment. The UL6 was in no worse condition than another tooth which had been filled in this way. Whilst the UL6 may ultimately have needed extraction (as any root filled tooth was prone to fracture), this was not at the point complained about. The Ombudsman found failings in the Dentist’s record keeping, a lack of discussion with Ms A to ensure she was able to properly decide to agree the extraction, that the UL6 did not require extraction at that time and failings in the way the Company had dealt with the complaint (including its engagement with the Ombudsman’s investigation).

The Ombudsman made recommendations which were fully accepted by the Company. It agreed to apologise to Ms A for the failings identified and its complaint handling, and to pay her redress of £1000 (as a contribution to her private restorative treatment) and £250 for complaint handling. The Company also agreed to share the report with the Dentist to reflect on his care, as well as sharing it with all its dental teams for wider learning. Finally, the Company agreed to review its complaint handling policy and website information to ensure it aligned with the requirements for dealing with NHS complaints in Wales.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201707248 – Report issued in July 2019

Ms B complained about events surrounding her maternity care at Royal Gwent Hospital (“the Hospital”). Ms B is of the Muslim faith and is vegan. She said that on first attending the Hospital she was wrongly discharged only to be called in later, admitted, and then had to undergo an emergency Caesarean section (C-section). Ms B’s birth plans had expressly stated that she wanted female only care and that her baby was not to be removed from her at any time, or to be given any formula milk or supplements. Ms B complained that none of her wishes had been followed as a male doctor had performed an intimate post-delivery procedure, which was a source of great distress to her. She also said that her baby was removed and given supplements at that time. Ms B said that Hospital staff had not respected her cultural beliefs.

The Ombudsman found that at the point of her first admission, there was no clinical reason why Ms B could not have gone home. That had no bearing on her subsequent need for a C-section delivery. The Ombudsman was satisfied from the records that Ms B’s baby was not given formula or supplements. Other than once, for a very brief period (to settle the baby while Ms B rested), there was nothing to show that the baby was taken from Ms B. These complaints were not upheld. The Health Board said that the female doctor left to deal with other birthing mothers and so, regrettably, a male doctor had to complete the procedure. The Ombudsman recognised Ms B’s distress on this issue. However, he was satisfied that the Health Board had due regard for Ms B’s culture and human rights (Articles 8 & 9). It had ensured she was cared for throughout by female staff apart from this instance. Given other mothers’ needs at a busy time, when Ms B was safely delivered of her baby, the Health Board was entitled to interfere with Ms B’s Article 8 rights in order to ensure sufficient regard for the similar rights of other mothers that night. However, the Ombudsman noted that communication with Ms B at the time, and later in responding to her complaint on this issue, could have been clearer. The Health Board’s initial response was confusing and contradictory. Additionally, a record keeping issue was identified. To this limited extent, a finding of maladministration causing injustice to Ms B was made, to partly uphold the complaint.

The Ombudsman recommended that the Health Board should apologise to Ms B for the above communication failings, pay redress of £250, that the report be shared with Hospital maternity staff as a learning point and that relevant staff be reminded about record retention processes.

Clinical treatment in hospital - Powys Teaching Health Board Case Number: 201803259 – Report issued in July 2019

Mr and Mrs X complained about the care and treatment Mr X received from the Health Board’s Memory Service. In particular, they complained that the Health Board did not provide Mr X with accurate information about his potential diagnoses, did not offer appointments and advice within a reasonable time, and did not prepare an appropriate Care Plan, or a Shared Care Agreement with Mr X’s GP. Mrs X also complained that she was not offered adequate support as the carer for Mr X.

The investigation found that Mr X's diagnosis of vascular dementia was changed to one of mixed dementia between September 2017 and February 2018, but that Mr X was not advised of this or given the opportunity to discuss this change with the Memory Service. The investigation partly upheld Mr and Mrs X's complaint that they did not receive appointments and advice within a reasonable time, noting that the appointments offered were outside the usual timescale, but there was no evidence to suggest this impacted on the overall care Mr X received. The investigation found that Mr X did have an adequate Care Plan, but that the Shared Care Agreement was not implemented correctly. The complaint that Mrs X was not offered adequate support as the carer for Mr X was not upheld, as it was determined that the Local Authority was the body responsible for this.

The investigation noted that the Health Board had recently developed an Operational Policy for the Memory Service which addressed some of the findings identified. It recommended that the Health Board should apologise to Mr and Mrs X, and pay to them the sum of £250 for their need to complain to the Ombudsman, and £50 for the inconvenience of repeatedly contacting the Health Board to obtain repeat prescriptions of Mr X's medication. It recommended that the Health Board should slightly amend its Operational Policy to include reference to situations where a diagnosis has been revised or changed, and that within six months, it should amend the Shared Care Protocol to clarify when the agreement with GP partners comes into effect.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) Case Number: 201802962 – Report issued in August 2019

Mr A complained about the standard of care and treatment his mother, Mrs B, received at both Ysbyty Ystrad Fawr and Royal Gwent Hospital. Mr A wished to know whether an earlier diagnosis of a heart attack and heart murmur should have been made and if this would have made any difference to his late mother's outcome. Mr A also complained about the robustness of the Health Board's complaint response.

The Ombudsman's investigation found that the care provided to Mrs B was reasonable and appropriate. He was also satisfied that even if Mrs B's cardiac condition had been diagnosed sooner her outcome would not have been any different. Therefore he did not uphold this aspect of Mr A's complaint. In relation to Mr A's concerns about complaint handling and poor communication with the family, the investigation found that these were broadly reasonable and timely. That said, he found no evidence that the family had been informed about Mrs B's high troponin level and the fact that a previous heart attack had caused the subsequent heart murmur. He concluded that this lack of clarification caused confusion to the family and the resulting shortcoming in communication added to the family's distress and caused an injustice. The Ombudsman to that limited extent only upheld this part of Mr A's complaint.

The Ombudsman recommended that the Health Board apologise to Mr A for the shortcoming in communication.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) Case Number: 201806695 – Report issued in August 2019

Mr B complained that the Health Board failed to obtain his informed consent before undertaking a prostate biopsy procedure, did not properly administer an antibiotic to prevent infection (which caused side effects), did not follow the clinic procedures and failed to provide proper aftercare. Mr B also complained that the Health Board did not consider whether it was appropriate to make any reasonable adjustments for him based upon a pre-existing condition and did not appropriately address his complaints.

The investigation found that the record of the events lacked sufficient detail and the Health Board took a 'one size fits all' approach to the consultation. The appointment was rushed and Mr B was not given adequate information to consent to the procedure. Mr B was vulnerable, owing to his pre-existing condition, and the clinicians concerned did not give due regard to this during the appointment. Further, the failure to fully consider the impact of Mr B's pre-existing condition and follow procedures which resulted in compromising Mr B's dignity led the Ombudsman to conclude that there might have been an impact on Mr B's Human Rights.

Whilst the complaint regarding the administration of the antibiotic was not upheld, it was accepted that Mr B might not have taken the medication at all if he had been properly informed of his options, and therefore uncertainty arose as to whether the side effects Mr B suffered could have been avoided. The investigation also found that the Health Board did not fully follow clinic procedures and did not provide adequate aftercare. Complaint handling failings were also identified.

The Ombudsman recommended that, within one month, the Health Board should apologise to Mr B and make a payment of £500 to redress the failure to consider his pre-existing condition when providing the one-stop-clinic service, make a payment of £125 to redress the failings identified in the complaint handling process, ensure that all staff involved in Mr B's care reflect on the content of the report with their supervisor and reflect on how the complaint handling could have been improved. He also recommended that, within three months, the Health Board should arrange training for the staff involved in Mr B's care on making reasonable adjustments. The Health Board accepted the report and agreed to carry out the recommendations.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case number: 201800771 – Report issued in August 2019

Mrs Y complained about the care and treatment that her late mother, Mrs X, received from Betsi Cadwaladr University Health Board about a number of health issues. This included the management of Mrs X's severe back pain in light of an incorrect MRI scan report, the diagnosis and treatment that she received during admissions to hospital in February and August 2017 respectively, and whether her blood tests results from 2 August required further investigation or treatment. Mrs Y also complained about the standard of record keeping and the way in which the Health Board had handled her complaint.

The Ombudsman concluded that the management of Mrs X's back pain would not have changed had the initial MRI report been correct and that there were no additional referrals or treatments that the Health Board could have offered her while she was awaiting a consultation with a spinal surgeon. He also determined that a diagnosis of stroke had not been missed when Mrs X had attended the Emergency Department on 17 February and that appropriate treatment options had been considered when she was later admitted with a stroke on 25 August. The standard of recording keeping from both these admissions was also found to have been broadly reasonable. Therefore, he did not uphold these aspects of the complaint. However, the Ombudsman found that it was not clear whether the Health Board had considered carrying out repeat blood tests in view of Mrs X's results on 2 August. Nevertheless, even if it had done so, Mrs X's medication would probably not have been changed and so this did not represent a significant injustice. As a result, this aspect of the complaint was partially upheld. The Ombudsman also determined that, whilst it was not unreasonable that the complaint response was delayed given its complexity, there was an initial lack of progress with the investigation and evidence of poor communication with both Mrs X (who had first made the complaint before her death) and Mrs Y. He upheld that part of the complaint on that basis.

The Ombudsman recommended that the Health Board apologise to Mrs Y and make her a redress payment of £250 to reflect his findings about complaint handling. He also recommended that the Health Board remind staff responsible for complaint handling of the importance of keeping complainants updated of progress in a timely manner, that it review the performance of the Radiology Department in responding to complaints and that the report be discussed with the Consultant Haematologist. The Ombudsman also suggested a number of improvement actions for the Health Board to consider voluntarily implementing. The Health Board agreed to implement the recommendations and improvement actions.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#)
Case Number: 201805301 – Report issued in August 2019

Mrs A complained about the management and care provided by the Emergency Department (“ED”) of Ysbyty Glan Clwyd when her mother, Mrs C, sustained pelvic fractures and an injury to her elbow following a fall while on holiday in Wales. Mrs A noted that her mother was 91 years of age, was hard of hearing and registered as partially impaired. Mrs A was also dissatisfied with the Health Board’s handling of her complaint.

The Ombudsman’s investigation found failings in Mrs C’s orthopaedic assessment, examination and discharge. The Ombudsman did not accept that the two pelvic fractures that the Orthopaedic junior Doctor identified were old. The failings identified were compounded by the absence of any senior orthopaedic review as well as failings during the assessment undertaken by the Occupational Therapy team prior to Mrs C’s discharge. The Ombudsman was critical that a vulnerable, elderly woman had been discharged back to a hotel without follow-up in circumstances that did not represent an appropriate and safe discharge. The investigation also identified that communication was not as effective as it might have been and that the Health Board’s complaint response was not sufficiently robust. Mrs A’s complaint was upheld.

The Ombudsman recommended that the Health Board apologise to Mrs A and her mother and ensure a system was in place for senior orthopaedic review of patients to be discharged without follow-up. Additionally, clinicians in the ED/OT Departments should be reminded to ask patients about any reasonable adjustment needed and document their response. Finally, the Health Board should review and learn lessons from Mrs A’s complaint and its complaint handling.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#)
Case Number: 201803733 – Report issued in August 2019

Mrs B complained about her late husband’s management and care when he attended the Hospital’s ED with chest and back pains. He died, aged 36, after he suffered a heart attack shortly after being discharged. The post-mortem revealed that he had severe heart disease. Mrs B was also dissatisfied with the Health Board’s complaint handling as well as the robustness of its complaint response.

The Ombudsman's investigation concluded that the on-call medical team should have referred Mr B to a Cardiologist for inpatient review given his multiple cardiovascular risks and the fact that as a diabetic he was more likely to present with atypical chest pain. The Ombudsman was also critical that NICE guidance on cardiac medication was not followed with no reasons being documented in Mr B's records for clinicians departing from the guidance. Mr B's clinical presentation meant the Ombudsman could not say with any certainty that even if he had been referred for cardiology review that his management and care and therefore the outcome for Mr B would have been any different. The injustice for Mrs B and the family was that they would have to live with the uncertainty of not knowing whether there were missed opportunities to have changed the outcome for Mr B. Administratively, the investigation identified shortcomings in the Health Board's complaint handling process and the robustness of its complaint response. The Ombudsman upheld Mrs B's complaint.

The Ombudsman recommended that the Health Board apologise for the failings identified and make a payment to Mrs B of £2,000 for the uncertainty the family now faced together with £250 to reflect shortcomings in complaint handling. The Health Board was asked to share the report with its on-call medical team to facilitate learning and to remind its complaint investigators of the importance of clarifying the status of 'independent' clinicians referred to in complaint response.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) Case Number: 201803138 – Report issued in August 2019

Mr A complained about his daughter, Child B's, management and care in relation to her heart condition. He was concerned about the impact delays in recommended follow-up investigations by Nevill Hall Hospital had on Child B and that it had contributed to her needing to be tube fed and other health concerns. Mr A was also dissatisfied with the Health Board's communication with the family and the robustness of its complaint response.

The Ombudsman's investigation found that broadly Child B's management and care was appropriate. However, he did find that a test to monitor Child B's heart activity was delayed and concluded this was a service failing. Given that this had not affected Child B's need for tube feeding or contributed to her other complex health issues, no significant injustice had been caused to Child B. Therefore, this part of Mr A's complaint was not upheld. The investigation did find the repeated delays in follow-up paediatric cardiology clinic appointments contributed to communication failings and to that extent upheld Mr A's complaint. The Ombudsman did not uphold Mr A's complaint concerning the complaint response, as he concluded the Health Board had broadly and appropriately addressed the points of concern the family raised.

By way of recommendations, the Health Board was asked to apologise to Mr A and his family for the failings identified. Additionally, if it had not already done so, the Health Board was asked to start to provide regular feedback to its Quality and Patient Safety Committee. This would enable the Committee to have some oversight of the capacity issues delaying follow-up paediatric cardiology care and the steps being taken to address the problem.

My Dentist - Talbot Green - Clinical treatment outside hospital Case Number: 201804889 – Report issued in August 2019

Ms X complained about the dental treatment she received at two dental practices between 1 May and 25 June **2018**. The investigation considered the following:

- a) The treatment that Ms X received between 1 May and 25 June at the First Practice; and
- b) the treatment that Ms X received between 14 June and 25 June at the Second Practice.

The investigation found that the care and treatment provided to Ms X was generally appropriate, with the exception of an emergency appointment on 14 June. It found that the dentist made an error of judgement when deciding on appropriate treatment for Ms X during this appointment. This resulted in a delay of six days before Ms X received appropriate treatment. During this time, Ms X was in pain which was considered to be an injustice. During the investigation, the Second Practice acknowledged and apologised for its failure to appropriately treat Ms X.

The Ombudsman recommended that the Second Practice should, within one month of the date of the report, provide Ms X with a written apology and financial redress for its failure to appropriately treat her symptoms when she presented as an emergency patient on 14 June.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201805589 – Report issued in August 2019

Mr B complained about the care his wife, Mrs B, received during her brief hospital admission between 14 and 15 February **2018** and following her diagnosis of Acute Coronary Syndrome, a term used to describe a range of conditions associated with sudden, reduced blood flow to the heart. Mr B said his wife's death should have been preventable. He also said that the Health Board failed to communicate effectively with him, and Mrs B, about her condition and that it did not investigate his complaint appropriately.

The Ombudsman found that Mrs B's collapse was likely to have been the result of a significant and rapid worsening of a longstanding, albeit unrecognised, heart condition. Once Mrs B had been diagnosed with ACS, she did not receive relevant appropriate cardiac monitoring and medication, and her diabetic needs were not adequately managed. However, given Mrs B's sudden and rapid deterioration, it appeared that even optimal care would probably not have changed the outcome.

The Ombudsman found no evidence that either the working diagnosis or the plan of care were explained to Mrs and Mr B during her admission. The Health Board apologised for this and reminded relevant staff of the importance of timely, effective and considerate communication. The Ombudsman also found that the Health Board failed to keep Mr B fully informed and updated on the complaint investigation process. The Health Board agreed to apologise for this failure and to provide feedback to relevant staff on these learning points.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number: 201803425 – Report issued in August 2019

Mrs J complained that Betsi Cadwaladr University Health Board failed to follow correct procedures when sectioning her daughter, Ms L, on 3 July 2017 under section 2 of the Mental Health Act 1983. Mrs J was also unhappy with the care and treatment Ms L received when an inpatient at a specialist mental health hospital between 3 and 18 July.

The Ombudsman's investigation found that the three individuals involved in assessing Ms L followed the correct procedures and appropriately explained their reasoning for why she needed to be sectioned. His investigation also found that Mrs J was given details of the Mental Health Review Tribunal for Wales, so she had the opportunity to appeal the decision to section her daughter. The Ombudsman did not uphold this part of the complaint.

However, it was noted that it was not clear in the notes what specific alternative specialised units were considered for Ms L. The Ombudsman did not make a formal recommendation regarding this; however, he did invite the Health Board to consider his comments with regard to future assessments.

The Ombudsman also considered that staff at the specialist mental health hospital gave appropriate consideration to Ms L's physical health including the treatment of a urinary tract infection. However, the Ombudsman did note that staff did not follow-up a gastrointestinal referral. Whilst this had no overall negative effect on Ms L's care, the Ombudsman did once again invite the Health Board to consider his comments and reflect on how to ensure such instances did not happen again.

However, the Ombudsman did find that whilst the Health Board followed correct procedure when employing the use of seclusion, and documented it clearly when it was used, Ms L's medical notes did not indicate clearly whether specialist behavioural support advice was available which, in the Ombudsman's view, might have reduced the need for seclusion to be used. The Ombudsman considered that this uncertainty was an injustice to Ms L and upheld this part of the complaint.

Finally, the Ombudsman had cause to consider the Health Board's approach to Ms L's human rights, specifically Articles 3, 6 and 8 of the Human Rights Act. The Ombudsman concluded that the threshold for all three Articles was not met and the actions of the Health Board were necessary, in particular with regard to the use of seclusion in order to protect not only Ms L, but to prevent harm to others.

The Ombudsman recommended that the Health Board apologised to Mrs J for the identified failings and shared the report with relevant staff so lessons could be learned and to identify any improvements.

[Hywel Dda University Health Board - Clinical treatment in hospital](#) Case Number: 201803042 – Report issued in August 2019

Mrs D complained about the care and treatment that her late mother, Mrs M, received at Glangwili Hospital's Emergency Department (ED) following a fall that she suffered while out shopping. Mrs D complained that, after conducting scans of her mother's head and neck, clinicians removed her cervical collar (which had been applied as a precaution) on the basis that her head scan was 'all clear'. Mrs M then suffered a cardiac arrest. Though she was successfully resuscitated, a separate report of Mrs M's neck scan was issued shortly after this which identified a cervical spine fracture. Mrs D complained that her mother's condition rapidly deteriorated after these events and that she passed away within a matter of days. Mrs D also complained that there were excessive delays and deficiencies in the way that the Health Board dealt with her complaint about these matters.

The Ombudsman upheld Mrs D's complaint that clinicians made a serious error in prematurely removing Mrs M's cervical collar. However, there was insufficient evidence to determine that Mrs M's reaction to the removal of the collar was in fact a cardiac arrest (it may have been an arrhythmia-related blackout) or to determine that her collapse contributed to her deterioration and death. The Ombudsman nevertheless considered that this uncertainty was in itself an injustice to Mrs M and her family and, to that extent, he upheld this element of the complaint. He also upheld Mrs D's complaint about the Health Board's handling of her complaint.

The Ombudsman recommended that the Health Board provides Mrs D with a fulsome written apology and makes a total payment to her of £1,500. He further recommended that the Health Board shares the report with ED physicians, nurses and radiologists at the Hospital for discussion and reflection. The Ombudsman also recommended that a copy of this report is shared with the Health Board's remote radiology provider and that the Health Board confirms that audits of the accuracy and turnaround time of outsourced urgent imaging studies are conducted regularly.

Finally, the Ombudsman recommended that the report is shared with the Concerns Team and that they are reminded of the need to ensure that formal complaint responses accurately reflect documented information held in medical records and are compliant with the provisions of complaint handling regulations.

The Health Board accepted and agreed to implement these recommendations.

[Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures](#)
Case Number: 201805129 – Report issued in September 2019

Mr X complained about the care that he received from Betsi Cadwaladr University Health Board ("the Health Board") after his diagnosis of prostate cancer in May 2018. In particular, he complained that the Health Board failed to arrange timely treatment following his diagnosis, failed to monitor the length of time that he had to wait to receive treatment (after referring him to a hospital in England), and failed to keep him updated. Mr X also complained that the Health Board's formal complaint response was inadequate.

The Ombudsman concluded that the Health Board promptly referred Mr X to the hospital in England and that it would have had no control of the latter's waiting lists. He did not uphold this aspect of the complaint. However, as the Health Board commissioned his treatment from the hospital, it retained responsibility for oversight of Mr X. It should have been aware of the delay and provided Mr X with a single point of contact with whom he could raise concerns and request information. In this respect, the Health Board did not make any attempt to request information from the hospital in England for some time after Mr X had first informed it about the delay in receiving a date for his surgery. In addition, Mr X was not given any meaningful, co-ordinated update about the situation at any point. The Ombudsman also concluded that the Health Board's complaint response was inadequate because it was issued before information requested from the hospital in England had been received. He also found that the complaint response was misleading in its statement that the hospital was investigating the complaint. As a result, he upheld these parts of the complaint.

The Ombudsman recommended that the Health Board apologise to Mr X and offer him a redress payment of £250 to reflect the findings that he identified. He also recommended that it share his report with staff involved in complaint handling for them to reflect on its findings. Furthermore, the Ombudsman recommended that the Health Board ensure that all patients referred for cancer treatment outside the Health Board's area are provided with a point of contact for raising concerns and obtaining information in cases of such delays. The Health Board agreed to implement the recommendations.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201803765 – Report issued in September 2019

Ms A complained that the Health Board failed to diagnose and treat the cause of her mother's ("Mrs B") lymphadenopathy (a disease affecting the lymph nodes) between March 2016 and June 2017 and failed to prescribe Prednisolone (a steroid medication often used for inflammatory conditions) or manage Mrs B's nutritional needs during her final hospital admission.

The Ombudsman found that appropriate steps were taken to try and reach a diagnostic position in terms of Mrs B's lymphadenopathy. He also found that, while Prednisolone was omitted during Mrs B's final hospital admission, he could not say that this weakened Mrs B or prevented her from receiving appropriate treatment. He did not uphold these complaints.

The Ombudsman found that relevant guidance in relation to nutritional management was not followed during Mrs B's final hospital admission and that a referral to a Dietician would have been appropriate given her weight loss and poor appetite. He upheld this complaint.

The Health Board accepted the Ombudsman's recommendations to apologise to Ms A, remind relevant staff of the importance of following relevant guidance on management of patients with poor nutrition/weight loss and review their training schedule to consider whether updated training on management of nutrition was indicated.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201803224 – Report issued in September 2019

Ms B complained about the care and treatment provided to her and her premature baby by Cardiff and Vale University Health Board. Ms B said the Health Board failed to manage and monitor her antenatal, childbirth and postnatal care appropriately, that it failed to give her baby adequate treatment in order to help him survive and it gave him an injection after he was born.

The Ombudsman found Ms B's baby was born too early to survive according to standard practice, the care and treatment provided to him was reasonable and there was no evidence to suggest he was injected; therefore, these complaints were not upheld. The Ombudsman found that whilst the overall clinical care and treatment provided to Ms B was reasonable and in accordance with standard practice, the neonatal team did not discuss options with her or her partner during labour, which denied them an opportunity to fully comprehend a difficult and distressing situation. Therefore, this element of the complaint was partly upheld.

The Health Board agreed to apologise to Ms B for the failing identified, to provide her with an explanation about how arrangements will be made for neonatologists to speak with the families in a similar situation, and to share the report with all relevant medical staff for critical reflection.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201803577 – Report issued in September 2019

Mrs A complained about the treatment and care provided for her late husband, Mr A, following an emergency admission to the Royal Gwent Hospital. Specifically, Mrs A complained about inappropriate treatment with non-invasive ventilation (“NIV”), a failure to meet Mr A’s nutritional and hydration needs, poor communication, a failure to allow her to spend time with Mr A after he died, and a poor and overly delayed response to her complaint.

The Ombudsman found that Mr A’s treatment with NIV was appropriate to his presenting condition and, although he was unable to eat or drink, his nutrition and hydration needs were also monitored appropriately. However, communication by nursing staff around Mr A’s treatment was not always clear, and aspects of Mr A’s personal care after death and the ongoing support provided to Mrs A and her family were found to be rushed and insensitive. Particularly, there was a failure to ensure that Mrs A was able to spend time with Mr A after he died. The Health Board’s response to Mrs A’s complaint also failed to fully address the concerns that she raised casing protracted correspondence and unnecessary delay.

The Ombudsman recommended that, within a month of the issue of the report, the Health Board should apologise to Mrs A for the failings identified and share the findings of his investigation with relevant nursing staff.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number: 201707595 – Report issued in September 2019

Mrs A complained about the care and treatment her father, Mr B, received from the former Cwm Taf University Health Board. Specifically, she complained that the Health Board took too long to diagnose Mr B’s bowel cancer, failed to explain that a diagnosis of bowel cancer was a potential outcome of the investigations being carried out, failed to identify a blockage in Mr B’s urethra before his hemicolectomy surgery (to remove part of the large bowel), that the consent process for the hemicolectomy was not appropriate and that the hemicolectomy was not carried out to an appropriate standard. She also complained that the Health Board failed to manage Mr B’s pain post-surgery, failed to identify and treat Mr B’s post-operative anastomotic breakdown (a leak from the surgical join) in a timely manner, and did not discharge Mr B appropriately from hospital, in particular in relation to care and support arrangements for Mr B’s stoma bag.

The Ombudsman did not uphold the complaint about delay in diagnosis as, although the target was not met, in this particular case it did not affect Mr B’s subsequent treatment. He upheld the complaint that Mr B was not informed that a diagnosis of cancer was a possible outcome of the investigations he was undergoing. This caused an injustice to Mr B and his family as the diagnosis was unexpected and came as a shock. The Ombudsman concluded that there was nothing to suggest Mr B had a narrowing of his urethra before surgery, and he also found that the hemicolectomy was carried out appropriately. He did not uphold these parts of the complaint. The Ombudsman upheld the complaints about pain management and that the second operation should have been done a few days sooner than it was. Although the outcome was likely to have been the same even if the operation had been done at an earlier stage, the extra discomfort and distress caused by the delay were an injustice to Mr B and his family. Finally, whilst the Ombudsman found that the decision to discharge Mr B was appropriate and the support given for his stoma was broadly reasonable, there was no evidence he was given written information on discharge. This was an injustice to him and his family, who found it more difficult to cope when he went home.

The Ombudsman recommended that Cwm Taf Morgannwg University Health Board (as it now is) apologises to Mrs A and Mr B and makes a redress payment of £1,500 to reflect the distress and upset caused by the failings identified. He also recommended that the Health Board conducts an audit of pain scores on the ward concerned, provides nursing staff with reminders about pain management and considers introducing a discharge checklist to ensure all relevant actions have been taken before patients are discharged.

Not Upheld

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital Case Number: 201803475 – Report issued in July 2019

Mr Y complained that the Health Board failed to act on his symptoms following several Emergency Department (“ED”) admissions between February and July 2017. As a result, Mr Y said he became very ill which resulted in an emergency admission on 31 July 2017 which led to him undergoing a small bowel resection (an operation to remove a damaged or blocked section of the bowel). Mr Y considered that his condition should have been diagnosed and treated sooner.

The Ombudsman found that the care and treatment by the ED and Surgical Teams during this period was within the bounds of acceptable clinical practice. The small bowel obstruction diagnosed following Mr Y’s attendance on 31 July, which led to surgery to remove part of his small bowel, was not related to his previous admissions. His symptoms were not indicative of a small bowel obstruction and he did not meet the criteria for early surgery at any of the ED attendances/surgical reviews prior to 31 July. The Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number: 201803376 – Report issued in July 2019

Mr Y complained about the care and treatment he received from the Health Board (between April and December 2017) for his cholesteatoma. He also complained about the delay in arranging surgery, despite being placed on the urgent waiting list.

The Ombudsman found that the care and treatment for Mr Y’s cholesteatoma was appropriate and that the referral for an examination under anaesthetic was reasonable as surgical management was the appropriate pathway for the treatment of Mr Y’s cholesteatoma. He was also satisfied that there was no delay in arranging Mr Y’s surgery. Mr Y’s complaint was not upheld.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201803223 – Report issued in July 2019

Ms A complained that the Consultant Specialist in Orthopaedic Medicine (“the Consultant”) advised her that he was unable to treat her with steroid injections as this treatment was no longer recommended by the National Institute for Health and Care Excellence (“NICE”) guidance and discharged Ms A from his care. Ms A said that as a result her GP referred her to another consultant for further treatment. Ms A said that had the Consultant made the referral it would have avoided the subsequent delay and pain she experienced. Ms A also complained about the Health Board’s handling of her complaint.

The Ombudsman was satisfied that the Consultant followed the Health Board's policy which was based on NICE guidance and therefore concluded that Ms A's discharge was reasonable and appropriate. He also concluded that there was no clinical reason for the Consultant to have made a referral to another clinical specialist and referral of Ms A's care back to her GP was again reasonable and appropriate.

In relation to Ms A's concern about complaint handling the investigation found that the Health Board's responses were reasonable and timely. The Ombudsman therefore did not uphold either aspect of Ms A's complaint.

[Cwm Taf University Health Board - Continuing care](#) Case Number: 201805593 – Report issued in July 2019

Mr A complained via a firm of Solicitors that Cwm Taf University Health Board's consideration of a claim for retrospective continuing NHS healthcare ("CHC") funding in respect of his late mother, Mrs A, was unsound. In particular, he was concerned that the Independent Review Panel ("IRP") which considered the claim decided that Mrs A was not eligible for CHC funding from the date of the start of the claim despite a different IRP finding her eligible up to and including the day before. Mr A considered that Mrs A's circumstances had not changed between those dates.

Whilst accepting that the difference in decisions between the two IRPs must seem odd to Mr A, the Ombudsman found that the Health Board and IRP had followed the correct process for determining the claim and that there was no evidence of maladministration in how they considered the matter. The Ombudsman did not uphold the complaint.

[Cardiff and Vale University Health Board - Clinical treatment outside hospital](#) Case Number: 201802548 – Report issued in July 2019

Mr Q complained about Cardiff and Vale University Health Board's Community Mental Health Team ("CMHT") ignoring his daughter's, Ms R, previous diagnosis and discharging her from its care thus depriving her of much needed treatment and support. Mr Q also said that the CMHT failed to refer Ms R onwards for appropriate support and it had not taken into account the effect of her condition on her immediate family.

The Ombudsman's investigation found that the CMHT did all it could for Ms R and that there was no evidence that it did not take Ms R's mental health problems very seriously. The Health Board was fully aware of Ms R's previous diagnosis a number of years earlier, however, recent assessments showed that she did not now reach the threshold for the same diagnosis and she was appropriately discharged from its services.

The Ombudsman also found that appropriate support was identified and offered to Ms R, and Mr Q, when CMHT services were closed to Ms R. He noted that it was a shame that Ms R did not engage with these services as they might have benefitted her.

The Ombudsman did not uphold Mr Q's complaint.

Cwm Taf University Health Board - Clinical treatment in hospital Case Number: 201802702 – Report issued in July 2019

Mr A complained that the former Cwm Taf University Health Board failed to treat his knee injury causing him unnecessary and prolonged pain.

The investigation found that appropriate investigations of the knee injury had been made. The investigation also found that the First Orthopaedic Surgeon's decision to refer Mr A for physiotherapy and to the Pain Management Clinic was reasonable. Finally, the investigation found that the First Orthopaedic Surgeon's decision not to undertake surgery was reasonable and based on the information available to him. The complaint was not upheld.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number: 201804209 – Report issued in August 2019

Mr X complained about the delay in Betsi Cadwaladr University Health Board referring his brother, Mr Y, for surgery before his lung cancer became inoperable. Mr X also raised concerns about the accuracy and completeness of the Health Board's complaint response.

The Ombudsman found that, although there was a delay between Mr Y's diagnosis and his referral for surgery, this delay had been necessary due to the need to first treat his influenza (the flu) and investigate his ongoing confusion and memory problems. The Ombudsman also noted that there had been a slight delay between the decision to refer Mr Y for surgery at a hospital in England and the formal referral letter being sent. He concluded that these delays did not lead to the tumour becoming inoperable. This was because the exact nature of the tumour, such as its involvement with the heart and key veins, was not apparent from the pre-operative scans. As a result, it was only during the surgery itself that the exact nature of the tumour was fully established and so was discovered to be inoperable. The Ombudsman also concluded that, overall, the complaint response had reasonably explained the delay in referring Mr Y for surgery and was an accurate reflection of the medical records. He therefore did not uphold the complaints.

Abertawe Bro Morgannwg University Health Board - Patient list issues Case Number: 201807146 – Report issued in August 2019

Miss G complained about the delay her mother, Mrs X, experienced waiting for knee replacement surgery. Mrs X was referred to the Health Board by her GP in March 2018 and was put onto the Surgeon's urgent waiting list in September 2018. Mrs X decided to have the surgery carried out privately in January 2019.

The Ombudsman recognised that waiting times for treatment will sometimes exceed the NHS target time of treatment within 36 weeks of referral. He noted that Mrs X had waited some 41 weeks when she had the surgery privately; however, he found no evidence that Mrs X's surgery was not appropriately prioritised, or that her clinical need was such that it should have been further expedited following falls she sustained or a letter from her GP requesting the surgery be expedited. He did not uphold the complaint.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201805217 – Report issued in August 2019](#)

Miss S complained about her mother's care at Wrexham Maelor Hospital between 22 February and 5 March 2018. Her complaint related to the prescription of medication, a lack of 'joined-up' care and communication between teams, the diagnosis of community acquired pneumonia and the quality of the clinical records.

The Ombudsman found that withholding the medications Mrs S had previously been taking was appropriate in view of the deterioration in her kidney function, and did not have an adverse effect on her heart. Mrs S had always been under the care of Consultants in their capacity as General Physicians, and there was no lack of communication between the teams involved. The Ombudsman's Professional Adviser agreed that Mrs S had been suffering from pneumonia, and that she had received appropriate treatment. The Ombudsman found that the records were of an acceptable standard. He did not uphold the complaint.

[Cwm Taf University Health Board - Clinical treatment in hospital](#) [Case Number: 201803471 – Report issued in August 2019](#)

Mrs T complained about her treatment for back pain between July and October 2017. Despite undergoing physiotherapy and hydrotherapy sessions, Mrs T continued to complain of stiffness and aching, and requested a scan. The Health Board said this would only be carried out when indicated and to inform future treatment; Mrs T did not attend a further appointment, and subsequently had a private scan followed by injections and surgery.

The Ombudsman found that Mrs T received appropriate treatment which was suitable for her condition. The Health Board's guidelines for scans accorded with national guidelines, and it was possible that, had Mrs T attended her last appointment, she might have been referred for further investigations or a second opinion. He did not uphold the complaint.

[Hywel Dda University Health Board - Clinical treatment in hospital](#) [Case Number: 201802485 – Report issued in August 2019](#)

Ms B complained about the care and treatment she received from Hywel Dda University Health Board between 2014 and 2016 concerning abdominal pain, gallstones and a gallbladder removal. Ms B said she was told in 2015 that gallstones were nothing to worry about and her condition was not taken seriously by the Health Board until she was admitted to hospital in June 2016 with gallbladder problems. Ms B said her gallbladder had to be removed and the Health Board had failed to provide her with appropriate care and treatment following the admission and procedure.

The Ombudsman found that Ms B was seen for symptoms unrelated to gallstones between 2014 and June 2016, and the overall clinical care and treatment provided to her during this period, and following her subsequent admission and procedure, was of an acceptable standard and in line with guidance. The Ombudsman also found some shortcomings in record keeping and care planning related to nursing care over a limited two-day period which did not impact significantly on Ms B's condition. However, the Health Board apologised for this, it also confirmed it had identified areas for improvement and taken action to address the issues. Therefore, Ms B's complaints were not upheld.

Dyfi Valley Health - Machynlleth Health Centre - Clinical treatment outside hospital Case Number: 201801972 – Report issued in August 2019

Mr B complained about the care and treatment provided by a GP Practice within the area of Powys Teaching Health Board regarding a wound on his back and the way it dealt with his complaint. Mr B said the Practice did not assess his condition appropriately, that it misdiagnosed a wound infection and failed to make a prompt orthopaedic and magnetic resonance imaging (MRI) referral. Mr B also said information in the Health Board's complaint response concerning his condition was wrong and had been misinterpreted to aid the Practice's case.

The Ombudsman found that the overall clinical care and treatment provided by the Practice to Mr B was of an acceptable standard and in line with guidance. The Ombudsman found some shortcomings in how the Practice had documented consultations which did not impact significantly on Mr B's condition. However, the Practice apologised for the distress and anxiety caused and the difficulties Mr B had experienced. The Practice confirmed it had identified learning points and offered to meet Mr B to discuss his care and the changes it had made to address issues. The Practice also confirmed it had not seen a copy of the Health Board's final response before it was sent to Mr B and agreed it was not consistent with his records. The Practice advised it had taken steps to ensure that in the future the Health Board would send finalised responses for review before they are passed to the complainant. Therefore, Mr B's complaints were not upheld.

MyDentist Tonyrefail - Clinical treatment outside hospital Case Number: 201804895 – Report issued in August 2019

Ms X complained about the dental treatment she received at two dental practices between 1 May and 25 June **2018**. The investigation considered the following:

- a) The treatment that Ms X received between 1 May and 25 June at the First Practice; and
- b) the treatment that Ms X received between 14 June and 25 June at the Second Practice.

The investigation found that the care and treatment provided to Ms X was generally appropriate, with the exception of an emergency appointment on 14 June. It found that the dentist made an error of judgement when deciding on appropriate treatment for Ms X during this appointment. This resulted in a delay of six days before Ms X received appropriate treatment. During this time, Ms X was in pain which was considered to be an injustice. During the investigation, the Second Practice acknowledged and apologised for its failure to appropriately treat Ms X.

The Ombudsman recommended that the Second Practice should, within one month of the date of the report, provide Ms X with a written apology and financial redress for its failure to appropriately treat her symptoms when she presented as an emergency patient on 14 June.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number: 201802680 – Report issued in August 2019

Mr O complained that his late wife was incorrectly diagnosed with sarcoidosis (a condition causing inflammation within body tissues, usually in the lungs, due to an overreaction by the body's immune system) and that she should have been diagnosed with tuberculosis, which she was found to have had post mortem. Mr O was concerned that his wife would have survived had she been diagnosed with tuberculosis and received treatment.

The Ombudsman found that the clinicians treating Mrs O had considered the possibility that she might have tuberculosis and had arranged a number of appropriate tests for it, all of which were negative. On the basis of the evidence available at the time, the clinicians were entitled to conclude that Mrs O was unlikely to have tuberculosis, and there were no other investigations that they could reasonably have considered to exclude it. The diagnosis of sarcoidosis was reasonable on the basis of the symptoms Mrs O was experiencing. The Ombudsman therefore did not uphold Mr O's complaints.

[Hywel Dda University Health Board – Clinical treatment outside hospital](#)
Case Number: 201804142 – Report issued in September 2019

Ms C complained that her daughter, Ms B, had recently been diagnosed with Ehlers Danlos Syndrome Type III (EDS type III - a genetic disorder of the connective tissues, type III is often referred to as the hypermobile type and is characterised by loose/unstable joints). Ms C complained that it was not reasonable that the Health Board did not diagnose Ms B with this condition sooner. She also complained that the failure to diagnose Ms B sooner had a negative impact on the care and treatment she should have received.

The investigation found that it was reasonable that the Paediatrician did not make a diagnosis of EDS type III as he instead used an equivalent term Benign Joint Hypermobility Syndrome. The investigation found that appropriate clinical tests were undertaken to rule out any underlying physical cause and using the term EDS type III would not have altered the management of the care. Overall the management was appropriate. The complaint was not upheld.

[Waterside Medical Practice – Clinical treatment outside hospital](#)
Case Number: 201807222 – Report issued in September 2019

Mrs X complained about the way in which a GP Practice in the former area of Abertawe Bro Morgannwg University Health Board, now Swansea Bay University Health Board, handled her daughter's ("Miss X") blood test results in November 2017. In particular, she complained that the Practice failed to interpret her daughter's blood test results correctly and take appropriate action. She also said that the Practice had failed to inform Miss X that she required a prescription for folic acid. Miss X later developed papilloedema (the swelling of the optic disc caused by increased pressure around the brain) and was diagnosed with idiopathic intracranial hypertension. Due to worsening symptoms, which included increasing visual impairment, Miss X was subsequently fitted with a shunt.

The Ombudsman concluded that Miss X's blood test results were correctly interpreted and that it had not been necessary to treat the two slightly raised levels that had been identified. He also determined that a direct causal link between any action taken (or not taken) in response to these blood test results and Miss X's later diagnosis was implausible. Whilst it was possible that the slightly raised levels were a non-specific response to the early development of intracranial pressure, the latter was not a diagnosis that a GP could have reasonably been expected to make based on Miss X's initial blood tests results and presenting symptoms.

The Ombudsman also found that the documentary evidence indicated that the Practice had made one attempt at contacting Miss X about her blood test results. Whilst he considered that it might have been logical for the Practice to have contacted Miss X by post after its attempt at contact by telephone had been unsuccessful, the Ombudsman also noted that there did not appear to be any guidance that stipulates what further action the Practice should have taken under the circumstances. As a result, he did not consider this to amount to failure on the part of the Practice. He also found

that, even if there was a failure by the Practice to inform Miss X of the results and prescription, it was unlikely that the lack of folic acid would have caused any harm and would not have been related to her later medical problems. He therefore did not uphold the complaints. However, the Ombudsman invited the Practice to consider, as learning points, repeating blood tests where there are minor abnormalities and the use of other methods of contact with patients when an attempt by telephone is unsuccessful.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#)
Case Number: 201803518 – Report issued in September 2019

Mr A complained about the treatment that he received between 4 August 2017 and 16 April 2018, in relation to a fracture to his right calcaneum (heel bone), from Aneurin Bevan University Health Board.

The Ombudsman concluded that conservative management was not an unreasonable treatment option to pursue at the time of the fracture and that a CT scan would only have been necessary if surgical intervention was being considered. Whilst the Ombudsman noted that an early reconstruction could have potentially avoided a mal-united fracture, he was, in view of the professional advice that he received, unable to conclude that surgery would have been likely to reduce the risk of the ongoing pain and disability that Mr A had subsequently experienced. The later need to operate on Mr A's foot, in order to treat this pain, was a different situation to original considerations about how to treat the position of the fracture and did not necessarily mean that he should have only received surgery as the initial treatment. He also considered that any communication issues between the Health Board and Mr A, particularly as he believed the fracture was originally non-displaced, did not have a significant impact on the overall outcome. As a result, the Ombudsman did not uphold the complaint.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#)
Case Number: 201805326 – Report issued in September 2019

Mr X complained about the insulin and pain relief management that his late grandmother, Mrs Y, received at Princess of Wales Hospital between 20 and 21 May 2018.

The Ombudsman found that the Health Board had prescribed the correct dosage of insulin to Mrs Y on 20 May. As Mrs Y's condition had deteriorated in the early hours of 21 May, she was receiving end of life care and further doses of insulin were not required. The Health Board prescribed pain relief as part of Mrs Y's end of life care but, as there was no evidence to suggest that Mrs Y was in pain, no pain relief was administered. The Ombudsman found that the management of Mrs Y's pain and end of life care was appropriate. Mr X's complaints were therefore not upheld.

[Cwm Taf University Health Board - Clinical treatment outside hospital](#)
Case Number: 201807345 – Report issued in September 2019

Mr T complained that the Health Board's District Nursing Team failed to ensure that necessary blood tests, requested by his mother's GP on 5 March 2018, were carried out promptly. The GP had noted that the blood tests should have been carried out within two working days but samples were not taken until after Mr T enquired about it on 20 March.

The Ombudsman found that the referral from the GP was not directed through the appropriate communications hub, which is the point of contact for all referrals and communications to the District Nursing Team. Therefore, the request was not communicated to the District Nursing Team until Mr T's enquiry. Once it was made aware of the request, the District Nursing Team visited Mr T's mother the next day to take the blood samples for testing. The Ombudsman did not uphold the complaint.

Early Resolution or Voluntary Settlement

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#)
Case Number: 201902115 - Report issued in July 2019

Mr X complained about the failure by the legal services department of the Health Board to write to him to make an offer of redress in respect of his complaint, after it had determined that a qualifying liability to him existed. His complaint to the Health Board was about a delay in the diagnosis of a fracture of his daughter, Y's, ankle in April 2018.

Following contact from the Ombudsman's office, the Health Board wrote to Mr X with an offer of redress. The Ombudsman considered the action the Health board took was reasonable, and the complaint was settled on this basis.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#)
Case Number: 201901618 – Report issued in July 2019

Mrs A complained about the lack of a key worker to help/support those affected with stage 4 breast cancer. She remained unhappy with the Health Board's response to her as she felt that the response did not answer her concerns. The Ombudsman contacted the Health Board who has agreed a member of its Cancer Team will arrange to meet with Mrs A to discuss her needs and what assistance can be offered to her. Mrs A's case has been settled on this basis.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#)
Case Number: 201901657 – Report issued in July 2019

Mrs C complained about the time her husband waited for appointments and treatment within three different departments of the Health Board. She also complained about the manner in which the Health Board handled her complaint.

The Ombudsman found that the Health Board's response to Mrs X's complaint explained the waiting times for treatment; however it did not address her concerns about the appointments system or the way her complaint was handled.

The Health Board agreed to provide a further response to Mrs X, within six weeks, covering the concerns she raised about the appointments system and the complaints handling.

Beechwood Surgery - Clinical treatment outside hospital Case Number: 201902070 – Report issued in July 2019

Mrs X complained that the Surgery had failed three times to send a referral for her son to the Child and Adolescent Mental Health Service (“CAMHS”). Mrs X said that the delay in sending the referral had exacerbated her son's mental health.

The Surgery agreed to undertake the following in settlement of Mrs X complaint:

By 9 August 2019:

- 1) Provide Mrs X with a formal response to her complaint and offer her an apology for the delay in its response.
- 2) Explain to Mrs X what its policy is when dealing with CAMHS referrals, and what new safeguards it has now implemented to ensure that referrals to CAMHS have been received.
- 3) Ensure that the Surgery has appropriate processes in place to deal with complaints about its service, in line with the requirements of the ‘Putting Things Right’ regulations.

The Ombudsman considered this to be an appropriate resolution to the complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number: 201901149 – Report issued in July 2019

Mrs A complained about the treatment she received which related to the pain she was experiencing in her ovaries, resulting in their removal. Mrs A complained that the Health Board had not considered her symptoms appropriately and that there was a significant delay in it responding to her concerns. Mrs A also complained that she wanted a better understanding of the complaint, and a copy of the expert's report.

The Ombudsman found that there had been a delay in Mrs A receiving a response including any timely updates, and notification of an instructed external expert. The Ombudsman also noted that Mrs A had not received a response to her outstanding concerns and considered that the matter was open to early resolution.

The Health Board agreed to apologise to Mrs A, pay her £250 to address her time and trouble in pursuing her complaint, address her outstanding concerns, provide her with the expert's report and hold a meeting with her to discuss her concerns.

Swansea Bay University Health Board - Clinical treatment in hospital Case Number: 201901666 – Report issued in July 2019

Ms S complained that the Board had failed to in its care and treatment of her whilst she was in the delivery stages of her pregnancy in September 2017. She complained that a decision was made to carry out a forceps procedure and episiotomy rather than give her longer to attempt a natural delivery. She further complained about the professionalism and attitude of one of the midwives who cared for her.

She further complained about the delays by the Board in arranging a local resolution meeting with her following its written complaint response to her in October 2017. Lastly she complained of the failure of the Board to update her regarding an action from that meeting to speak with the midwife about her attitude.

The Ombudsman found that the care and treatment provided to the complainant appeared to be reasonable. He was, however, concerned that there had been a lack of communication by the Board and that there had been a delay in arranging a local resolution meeting with her regarding her complaint.

The Board agreed to:

- 1) Write a letter of apology to her confirming the date when the midwife was spoken to and apologise for not doing so sooner.
- 2) Offer an ex- gratia payment of £250 in recognition of the time and trouble taken by her to make her complaint.

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

The Ombudsman considers that this provides a reasonable resolution to this complaint.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201901118 – Report issued in July 2019](#)

Mrs X complained about the treatment that her late husband received from the Health Board in February 2018, when he was diagnosed with hepatocellular carcinoma. Mrs X complained that her husband's care fell below the standards which she expected. Although the Health Board had provided a response to Mrs X's initial complaint, she remained dissatisfied with the response which raised further concerns which she considered ought to be addressed.

The Investigation Officer noted that the concerns which Mrs X sought to raise with the Ombudsman, had not previously raised with the Health Board. These concerns related to whether proper consideration had been given to her husband's existing medication and medical conditions (physical and mental health) and the lack of communication between the Health Board and the family.

Following a discussion with the Health Board it agreed to provide a further written response to Mrs X within 30 working days of the decision letter being issued.

The Ombudsman was satisfied that the actions which the Health Board said it would take was reasonable and would resolve Mrs X's complaint.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201901111 – Report issued in July 2019](#)

Mrs X complained about the treatment that her late husband received from the Health Board between September 2017 and February 2018, when he was diagnosed with hepatocellular carcinoma. Mrs X complained that her husband's care fell below the standards which she expected. Although the Health Board had provided a response to Mrs X's initial complaint, she remained dissatisfied with the response which raised further concerns which she considered ought to be addressed.

The Investigation Officer noted that the concerns which Mrs X sought to raise with the Ombudsman, had not previously been raised with the Health Board. These concerns related to whether proper consideration had been given to her husband's medical conditions; whether appropriate pain relief had been administered and checks carried out post surgery; and the circumstances surrounding her husband's death.

Following a discussion with the Health Board it agreed to provide a further written response to Mrs X within 30 working days of the Ombudsman's decision being issued.

The Ombudsman was satisfied that the actions which the Health Board said it would take was reasonable and would resolve Mrs X's complaint.

[Welsh Ambulance Services NHS Trust - Ambulance Services](#) Case Number: 201901795 – Report issued in July 2019

Miss X complained to the Ombudsman about the delay before an Ambulance from the Welsh Ambulances Services NHS Trust attended to her late mother following an emergency call. Whilst Miss X had explained to the Trust's emergency call handlers, her mother's condition, she was aggrieved that the Trust had categorised her mother's category of urgency as "Amber 1" instead of the highest possible level namely "Red".

The Ombudsman considered there were other aspects of the complaints which Miss X had made to him to which he considered Miss X had received a reasonable response. However, the Ombudsman considered that the explanation provided to Mrs X by the Trust lacked sufficient explanation about why the level of urgency for the need to attend to her mother was considered to be Amber 1 instead of Red.

The Trust agreed to provide Miss X with a more detailed explanation (if she wished to receive one) of why it considered that the call to attend to her mother should be prioritised as Amber 1 and not Red.

[Hywel Dda University Health Board - Clinical treatment in hospital](#) Case Number: 201807678 – Report issued in July 2019

Mr X complained about the Health Board's initial management of a penetrating wound to his neck when he attended the Emergency Department at Withybush Hospital. Specifically, he was concerned that there had been a failure to examine the wound properly and to undertake a scan for retained material before he was discharged.

Following contact from the Ombudsman's office, the Health Board reviewed the records again and identified that the Junior A&E Doctor who treated Mr X should have consulted with a more senior colleague before he was discharged and that he should probably have been referred to a specialist for an opinion and further treatment.

In order to settle Mr X's complaint, the Health Board agreed to engage an independent expert to determine whether there had been a breach of duty of care in accordance with the NHS Complaints Procedure. The Health Board said it would review and implement the recommendations of the independent expert, offer a payment to Mr X to reflect the suffering he had experienced, and apologise and make an additional payment for the shortfalls in his care and its inadequate complaint investigation.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number: 201803762 – Report issued in July 2019

Mr C complained about Cardiff and Vale University Health Board's overall care and treatment of him from September 2017 onwards. In particular, the Health Board's failure to refer him to a specialist hospital following a CT scan in September 2017 that resulted in a delay in his diagnosis of liposarcoma.

The Ombudsman began an investigation and, following receipt of Mr C's medical records, noted that the Health Board had failed twice to refer Mr C to a specialist multidisciplinary team at a neighbouring health board to consider his diagnosis of liposarcoma. When a referral was finally made on Mr C's behalf, there had been a delay of approximately eight months.

When the Health Board was notified of this finding, it agreed to settle Mr C's complaint by appointing an expert and considering, under the NHS Wales Putting Things Right complaints process, whether a qualifying liability existed in Mr C's case, and if so, whether redress would apply.

In accordance with regulation 14 of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, the Ombudsman discontinued his investigation

Margaret Street Practice - Clinical treatment outside hospital Case Number: 201902068 – Report issued in August 2019

Mr A complained about his GP practice ("the Practice"). Mr A said that he had made repeated visits to see his doctor about abdominal pain, but that he had been offered no treatment or further investigation leaving him in pain. Further, Mr A was unhappy about the way in which a named doctor ("the Doctor") had spoken with him during one consultation, saying it had made him feel 'fobbed off' and that he had received a 'second class service'. Mr A wrote to the Practice to complain on 14 May 2019 but received no response or any contact about it. Mr A was anxious to get a diagnosis for his health problem.

The Ombudsman noted that securing a diagnosis for Mr A was not something he could guarantee, but he was concerned that Mr A had not had any contact concerning his formal complaint. The delay amounted to maladministration, but the Ombudsman felt the complaint to him was capable of resolution without formal investigation. He contacted the Practice and it agreed to undertake the following actions to resolve Mr A's complaint:

- a) To offer Mr A an appointment within 10 days with another GP at the Practice (given the concerns expressed about the Doctor) to discuss and examine his symptoms of abdominal pain.
- b) To provide a written response to Mr A's complaint and an apology for the failure to respond to it in a timely way (within 14 days).

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201901455 – Report issued in August 2019

Mr X complained about the care provided by a Locum Consultant at the Health Board. In particular, he complained that the prescribing of a particular medication was not based on an appropriate assessment of his presentation.

The Ombudsman noted that the Health Board had responded to the complaint about the Locum Consultant. However, its response did not cover the complaint about the standard of clinical care.

The Ombudsman asked the Health Board to provide a further written complaint response to Mr X covering the concerns about the standard of clinical care, and in particular:

- 1) Whether the medication was clinically indicated in Mr X's case, and;
- 2) Whether the decision to prescribe the medication was based on an appropriate assessment of Mr X's presentation at the time.

The Health Board agreed to provide this further response to Mr X within three weeks.

[Skewen Medical Centre - Clinical treatment outside hospital](#) Case Number: 201902397 – Report issued in August 2019

Miss X complained that Skewen Medical Centre ("the Surgery") misdiagnosed her mother's cancer. She said that this was because a lesser experienced GP did not recognise the cancerous lumps. Miss X said she had not received a formal written response to her complaint.

The Surgery agreed to undertake the following in settlement of Miss X complaint.

By 21 August, the Surgery agreed to:

- a) Provide Miss X with a formal written response to her concerns and apologise for the delay in its response.
- b) Reiterate its offer of a meeting to discuss Miss X concerns in person with the practice manager and relevant clinical staff.

[Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures](#) Case Number: 201902372 – Report issued in August 2019

Mr X complained that a referral for hydrotherapy had been rejected by the Health Board. He said that the treatment had been recommended, but he was told it was not appropriate even though an assessment had not been done.

The Ombudsman found that an assessment of Mr X's needs had not been fully completed and the decision not to provide him with hydrotherapy had not been properly arrived at.

The Health Board agreed to promptly carry out an assessment for Mr X in accordance with the relevant guidance. It agreed to provide Mr X with the outcome of the assessment within ten working days of his appointment.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201901864 – Report issued in August 2019

Mr A complained that the Health Board had misdiagnosed a knee condition that he suffered with since January 2018. He believed that the misdiagnosis had meant that the Health Board had failed to give him appropriate advice regarding rest and treatment of the knee concerned. He was also unhappy with the response provided by the Health Board that did not consider whether the misdiagnosis regarding his knee condition had caused it to deteriorate and contributed to the onset of arthritis in the knee joint as a result of him using it as normal.

The Ombudsman found that there had been a lack of response by the Health Board to the specific issue raised by the complainant about the deterioration in his knee condition. It had also failed to co-ordinate a response to his complaint from his GP surgery (managed by it) and the Hospital.

The Ombudsman contacted the Health Board and it agreed to;

- 1) Provide him with a written apology for not responding to both parts of his original complaint as the public body in jurisdiction for his primary and secondary care.
- 2) Provide a response regarding whether misdiagnoses of his knee problem may have caused further deterioration and onset of arthritis.
- 3) Offer a payment of £100 as recognition of the time and trouble taken by him having to deal with two separate bodies unnecessarily and the delayed response by the Health Board having failed to identify secondary care issues contained in complaint.

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

The Ombudsman is satisfied that this provides an early voluntary resolution to Mr A's complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number: 201902773 – Report issued in August 2019

Miss X complained about the Health Board's failure to provide her with the minutes and recording of a complaint meeting held earlier this year.

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

- a) Issue a meaningful apology and an explanation as to why there was a delay in providing Miss X with the recording and minutes from the meeting - within the next 5 working days.
- b) Ensure that copy of the digital recording of the meeting of 18 March 2019 and summary of discussion is sent to Miss X - within the next two weeks.
- c) Provide financial redress in the sum of £100 for time and trouble in pursuing the complaint and in acknowledgement of the poor complaint handling.
- d) For the Complaint Team to review this element of service - to ensure this will not be reoccurring.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number: 201902368 – Report issued in August 2019

Mr and Mrs X complained about the care and treatment Mrs X received from the Health Board. Mr and Mrs X made a complaint to the Health Board but had yet to receive a response.

The Ombudsman was concerned that Mr and Mrs X clearly felt let down by the Health Board and therefore considered it appropriate that Mr and Mrs X should receive some reassurance that measures are being taken to lessen the likelihood of this happening again. The Health Board accepted that this was unacceptable and agreed to undertake the following action, in settlement of the complaint:

- a) Issue an apology letter with an explanation as to why there was a delay in response within the next 5 working days.
- b) Ensure a response to the outstanding issues in Mr and Mrs X letter dated 13 March is sent within the next two weeks.
- c) For the Complaint Team to review this element of service - to ensure this will not be reoccurring.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number: 201902470 – Report issued in August 2019

Mrs X complained that following an operation at the University Hospital of Wales her husband now has to self-catheterise for the rest of his life. Mrs X believed this was as a result of inadequate care in the placement of the catheter before her husband's operation.

The Health Board received a copy of Mrs X's complaint but failed to respond to the concerns and have agreed to do the following in settlement of her complaint.

Within **thirty working days**:

- a) Provide a written apology to the complainant for the oversight and delay in investigating the complaint.
- b) Investigate the complaint and provide a prompt 'Putting Things Right' response to the complainant.
- c) Investigate how the complaint has been overlooked.

Hywel Dda University Health Board - Clinical treatment in hospital Case Number: 201902384 – Report issued in September 2019

Ms E complained about a specialist independent report sought by the Health Board regarding the management and prescription of her medication over a number of years. Ms E said she was unhappy with the length of time it took for her to receive the report, that it was inaccurate and that she had tried to contact the Health Board without success to discuss her concerns. Ms E also said the Health Board had failed to provide her with records despite formal requests and it had supplied records to another person without her consent.

The Ombudsman found the Health Board sought the independent report in order to provide a full response to an earlier complaint from Ms E about the management and prescription of medication, and that she had waited several months to receive the findings and the final outcome. The Health Board acknowledged it had offered to discuss the independent report or any queries with Ms E if she was dissatisfied and agreed that as Ms E had been unsuccessful in her attempts to contact them, it would arrange a meeting to discuss her concerns about the report and the way it had dealt with provision of records.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#)
Case Number: 201902406 – Report issued in September 2019

Mrs X complained about the care of her deceased son and that his medication had blocked the arteries of his heart and led to his sudden death. Mrs X disagreed with the Health Board's response which said that there was not immediate cause for admission.

The Ombudsman assessed the complaint and noted that Mrs X had raised many new concerns and that she did not consider that all of her complaints had been addressed. The Ombudsman was of the view that the complaint was open to early resolution.

The Health Board agreed within a month to provide Mrs X with a response to a number of concerns and liaise with her about her complaint. The Health Board also agreed to meet with Mrs X to discuss her complaint following its response.

[Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital](#)
Case Number: 201902237 – Report issued in September 2019

Mr A complained that he had received a response letter from the Cwm Taf Morgannwg University Health Board. The letter had failed to fully address the issues he complained of. He had originally complained about failure in the care and treatment he had received when he attended the Accident and Emergency Department of his local hospital in February 2019, following a dog bite injury to his nose.

The Board had responded to his initial complaint by letter, but he had not received any response to his subsequent email to it raising issues he felt had not been responded to fully.

The Ombudsman contacted the Board and it advised that it had reviewed the issues raised and was in the process of preparing a response letter to him.

It agreed to:

- 1) Provide Mr A with a written letter of response to the further issues raised by him.

This will be completed within 10 working days of the date of this letter.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital Case Number: 201902653 – Report issued in September 2019

Mrs X complained that Betsi Cadwaladr University Health Board (“the Health Board”) failed to provide her with adequate care and treatment. Additionally, Mrs X complained that following a local resolution meeting, the Health Board failed to provide her with a copy of the audio recording or minutes from that meeting. Mrs X also complained that the Health Board made assurances to her, in the local resolution meeting, that it would provide her with evidence that policy reviews had been undertaken but subsequently failed to provide her with any such evidence.

In regards to Mrs X’s complaint about the care and treatment she received, the Ombudsman found that she was out of time to complain to the Ombudsman.

However, the Ombudsman found that the Health Board failed to provide Mrs X with minutes, a copy of the audio recording, and evidence that policy reviews had been undertaken.

The Health Board agreed to:

- a) Provide Mrs X with a written apology and explanation for the maladministration that occurred following the resolution meeting.
- b) Provide Mrs X with the opportunity to have a further meeting with the Health Board to address her original questions and any additional questions that have arisen, with minutes to be provided promptly thereafter.
- c) Provide Mrs X with evidence that policy reviews have been undertaken to improve future care for other patients.

The Ombudsman was satisfied that these actions addressed the complaint and decided not to investigate.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Number: 201903242 – Report issued in September 2019

Ms X first complained to the Health Board in February 2016. In its response to her in March 2016, the Health Board confirmed that a breach of duty of care had been identified and that it would request an internal expert to further review her care and provide a professional opinion on whether there was any qualifying liability. The Health Board failed to instruct an internal expert to review her complaint.

The Health Board confirmed that due to staff changes and changes to its system, the matter had been overlooked and an internal review had not been requested. The Health Board recognised that this was unacceptable and agreed to undertake the following in settlement of the complaint:

Within **30 working days**

- a) Send an apology letter to Ms X for the unacceptable delays.
- b) Payment of £750.00 for the unacceptable delay.

Within **16 weeks** of receiving all of the necessary medical records

- a) Request an independent external expert to review Ms X’s care.

Benefits Administration

Early Resolution or Voluntary Settlement

Ceredigion County Council - Housing Benefit
Case Number: 201901746 – Report issued in July 2019

Mrs X complained that the Council failed to remove her husband's details from the registry system following his death. She said that the Council had continued to ask for information regarding her benefit claims. Mrs X said that the handling of her complaint took too long and the payment offered to reflect this was insufficient. Also that, due to the time taken to process her claims, she was unable to claim a funeral payment.

The assessment found that some of the information requested by the Council was unnecessary and should have been requested sooner. However, the Council otherwise properly processed Mrs X's claims for benefit and had not caused her any detriment. A financial payment had already been offered to reflect delayed complaints handling. Mrs X could have provided information from the Council in respect of the funeral payment following the completion of her claim.

To put things right, the Council agreed to offer Mrs X a payment of £50 for the handling of her claim. It also agreed to repeat its offer of £75 in respect of the complaints handling.

Community Facilities, Recreation and Leisure

Powys County Council - Cemeteries/Graves/Headstones
Case Number: 201901438 – Report issued in August 2019

Mr X complained about the manner in which the Council had dealt with his request to scatter ashes on a family grave plot.

The Ombudsman found that, in the main, the Council's actions had been reasonable. However, the content of one of its initial letters to Mr X had been inaccurate about the legal requirements for permission to scatter ashes.

The Council therefore agreed to provide a formal written apology, for the misleading content of this letter, to Mr X within three weeks of the Ombudsman's decision.

Complaints Handling

Early Resolution or Voluntary Settlement

Betsi Cadwaladr University Health Board – Health
Case Number: 201901971 – Report issued in July 2019

Mr X complained that the Health Board had failed to respond to his complaint about the care and treatment it had provided to his late father.

The Health Board issued a letter to Mr X shortly after his complaint was made to the Ombudsman and apologised for its complaint handling delays.

During his enquires the Ombudsman established that the Health Board was undertaking a Serious Incident Review (“SIR”) in relation to elements of Mr X’s father’s care. However, the Ombudsman identified that the Health Board had not provided a response to Mr X following his complaint. Further to the Ombudsman’s enquiries, the Health Board agreed to complete the following in settlement of Mr X’s complaint by 31 July 2019.

- a) Issue the SIR report which will constitute its PTR response.

Charter Housing Association (Part of the Pobl Group) – Housing
Case Number: 201901800 – Report issued in July 2019

Ms X complained that the Association had failed to respond to her complaint and correspondence about repairs.

During his enquiries the Ombudsman established that the Association had not treated Ms X’s correspondence as complaints. Further to the Ombudsman’s enquiries, the Association agreed to complete the following in settlement of Ms X’s complaint by 12 August 2019.

- a) Provide a written apology to Ms X for the failure to deal with her correspondence as complaints and provide an explanation for this.
- b) Provide assurance to Ms X that processes will be reviewed to prevent this happening in the future.
- c) Provide a Stage 2 response to Ms X.
- d) Pay Ms X a sum of £125 for the time and trouble in bringing her complaint to the Ombudsman.

Newport City Council - Roads and Transport
Case Number: 201901797 – Report issued in July 2019

Ms X complained that the Council had failed to deal with an overhanging tree problem which she first reported on 23 October 2018. Ms X also complained that the Council failed to provide a response to her complaint.

The Ombudsman found that the Council had failed to provide a response to Ms X following her complaint. The Council therefore agreed to complete the following in settlement of Ms X's complaint by 30 July 2019.

- a) Write to Ms X and provide an apology for failing to issue a response to her complaint and provide an explanation for the communication breakdown.
- b) Reopen the complaint dated 25 February 2019 and provide a stage two response.
- c) Provide reassurance to Ms X of how her complaint will be handled and explain how the new process will avoid this happening in the future.
- d) Liaise with the appropriate department to reach a resolution to Ms X's main concern, the overhanging of the trees.
- e) Ensure the area of concern is inspected and a course of action agreed
- f) Advise Ms X of the outcome of the inspection.

Powys County Council - Adult Social Services Case Number: 201901684 – Report issued in July 2019

Mrs X complained that the Council changed her care provider without notice, consultation or consent. Mrs X also complained that the Council had failed to address or adequately respond to any of her communications.

The Ombudsman contacted the Council because he was concerned that under the relevant regulations, it is obliged to progress complaints to Stage 2 and it had not informed Mrs X of her right to do this in its Stage 1 response. The Council agreed to carry out the following in settlement of the complaint **by 1 August 2019:**

- a) Provide Mrs X with an apology for failing to highlight in its Stage 1 response her right to request a Stage 2 independent investigation
- b) Investigate Mrs X's complaint to the Ombudsman under Stage 2 of the Complaints Procedure.

Rhondda Cynon Taf County Borough Council - Housing Case Number: 201901678 – Report issued in July 2019

Mr X complained that the Council failed to recognise that his neighbouring property, which has been empty for over 15 years has an overgrown garden which has damaged his property and garden. Mr X also complained that the Council failed to take any action to remedy the issue.

The Ombudsman contacted the Council because he was concerned that the Council had failed to inform Mr X that his complaint email would not be treated as a formal complaint. The Council agreed to carry out the following in settlement of the complaint within 4 weeks of the Ombudsman's decision.

- a) Provide a written apology to Mr X for failing to inform him that his email was not going to be treated as a formal complaint
- b) Provide Mr X with an explanation as to why his email was not treated as a formal complaint
- c) Provide Mr X with a written explanation detailing the findings of the investigation.

Cardiff Council - Adult Social Services

Case Number: 201901543 – Report issued in July 2019

Ms X complained that following her complaint to the Council on 26 April 2019, apart from receiving an automated response the Council had not provided any further response.

The Ombudsman found that the Council had failed to formally acknowledge and respond to Ms X following her complaint. The Council therefore agreed to complete the following in settlement of Ms X's complaint within 20 working days of the Ombudsman's decision.

- a) Write to Ms X and provide an apology for failing to acknowledge and issue a complaint response and provide an explanation for this oversight.
- b) Provide reassurance to Ms X that the process will be reviewed to ensure this does not happen in the future.
- c) Provide its complaint response.

Bron Afon Community Housing Ltd – Housing

Case Number: 201901478 – Report issued in July 2019

Miss and Mr X submitted a number of complaints to the Housing Association, however received no reply.

The Ombudsman was concerned about the delay and that Miss and Mr X had not received a response. The Housing Association accepted that this was not an acceptable service and agreed to undertake the following action, in settlement of the complaint:

- a) Apologise for the delay.
- b) Issue a formal complaint response letter within 10 working days of our decision letter.

Isle of Anglesey County Council - Finance and Taxation

Case Number: 201804977 – Report issued in July 2019

Miss A complained about the Council's administration of her council tax. She said the Council had failed to collect the right amount by direct debit resulting in arrears that caused her financial hardship. Miss A also complained that the Council had provided her with conflicting information about the balance of historical arrears, and that it had failed to call her back to answer queries about her account.

On receipt of the complaint, the Council undertook a detailed review of Miss A's account. A computer software accounting error was identified, and immediate action was taken to ensure that Miss A was not at a financial loss. The Ombudsman found that, although Miss A had received conflicting information from her employer about her arrears balance, the balance, as advised by the Council, was correct at the time of writing. The difficulty Miss A had experienced in obtaining information about her account over the telephone related to single point of contact arrangements that were not unreasonable. However, it was noted staff had failed to direct Miss A to the single point of contact arrangements when she called.

The Council agreed to apologise to Miss A and to pay her redress of £50 in recognition of the difficulties she had experienced. The Council also agreed to report the software issue to its supplier for further investigation. The Ombudsman reminded the Council that its contact arrangements should not be so restrictive that account holders could be left waiting unreasonably for information.

Hafod Housing Association – Housing Case Number: 201902562 – Report issued in August 2019

Miss X complained that despite making eight complaints to the Association it had failed to follow up on her complaints regarding mould in her property.

During his enquiries the Ombudsman established that the Association had not treated all of Miss X's correspondence as complaints. Further to the Ombudsman's enquiries, the Association agreed to complete the following in settlement of Miss X's complaint by 17 September 2019.

- a) Provide a written apology to Miss X for the failure to deal with all her correspondence as complaints and provide an explanation for this.
- b) Provide assurance to Miss X that relevant staff will be provided with refresher training regarding complaint handling.
- c) Provide a Stage 2 response to Miss X.

Pembrokeshire County Council – Housing Case Number: 201902478 – Report issued in August 2019

Mr X complained that Pembrokeshire County Council ("the Council") had failed to respond to his complaint. The complaint had been sent to the Council by the Ombudsman in April 2019.

The Council agreed to undertake the following in settlement of Mr X's complaint:

By 19 August 2019:

- a) Provide Mr X with a substantive formal written response to his original concerns and apologise to him for the delay in its response.
- b) Offer Mr X a service payment of £100 for the delay in its response.

The Ombudsman considered this to be an appropriate resolution to the complaint.

Betsi Cadwaladr University Health Board – Health Case Number: 201901721 – Report issued in August 2019

Mrs X complained about the content of an investigation report which the Health Board commissioned an external organisation to produce. Mrs X was concerned at inaccuracies within the report and that the Health Board had failed to adhere to the NHS Wales complaints procedure. Mrs X also became aware of additional information relevant to the report which had been omitted from the final report. As a result Mrs X met with senior Health Board officials and was given an undertaking that outstanding questions she had would be put to the report's authors and she would be provided with a further response. As she had not received the response, she complained to the Ombudsman.

The Ombudsman contacted the Health Board and was told that Mrs X's questions had been referred to the Investigation Report's authors. The Health Board expected the author's to provide their responses to the Health Board by the end of August. The Ombudsman remained concerned at the length of time Mrs X was having to wait for her further responses. However, he was of the view, given that the Health Board was awaiting responses from outside the Health Board, it would be reasonable for the Health Board to provide Mrs X with the author's responses to her questions by 9 September 2019.

The Health Board agreed to provide Mrs X with the responses in accordance with the Ombudsman's proposal as set out above.

[Cwm Taf Morgannwg University Health Board – Health](#) [Case Number: 201902766 – Report issued in September 2019](#)

Ms X complained about the care her late mother received in hospital, in relation to inappropriate mobilisation following a fall, concerns regarding oxygen therapy and an incident in which she sustained a fracture to her left leg.

The Health Board explained that it was investigating the matter under the Serious Incident Review process, using a Root Cause Analysis ("RCA") approach but had not considered Ms X's complaint under the NHS Putting Things Right ("PTR") process. Following discussions with the Ombudsman, the Health Board agreed to complete the RCA by the end of October and to issue a formal complaint response to Ms X within 20 working days thereafter. Additionally, the Health Board agreed to review its procedures alongside all outstanding RCA's to ensure that complainant's could access the PTR process without delay.

The Ombudsman considered these actions to represent a reasonable settlement.

[Merthyr Tydfil County Borough Council - Various Other](#) [Case Number: 201902774 – Report issued in September 2019](#)

Miss X complained that despite making a complaint to the Council in 2018, it had failed to provide a complaint response. Miss X also complained on behalf of Mr & Mrs A who had made a complaint to the Council and had not received a complaint response.

During his enquiries, the Ombudsman established that the Council had failed to treat Mr & Mrs A's correspondence as a complaint. Further to the Ombudsman's enquiries, the Council agreed to complete the following in settlement of Miss X's complaint by 7 October.

- a) Provide an apology to Mr & Mrs A for the failure to treat their correspondence as a complaint.
- b) Provide a Stage 2 complaint response to Mr & Mrs A.

Cafcass Cymru - Childrens Social Services

Case Number: 201902252 – Report issued in September 2019

Mr X complained that Cafcass Cymru failed to deal with his complaint in accordance with its procedure. Whilst Mr X acknowledged that some of his complaint related to court matters, some did not. Mr X said that Cafcass had not contacted him to establish the nature of his complaint.

Cafcass accepted that it had not contacted Mr X about his complaint. It said this was because it considered the complaint to concern court matters, which were not subject to its complaints procedure.

In order to resolve the complaint, on receipt of a full complaint from Mr X, Cafcass agreed to consider it in accordance with its complaints procedure, including whether a full investigation was appropriate.

Betsi Cadwaladr University Health Board – Health

Case Number: 201901244 – Report issued in September 2019

Miss X raised concern with the Health Board regarding her experience with a member of the Home Treatment Team, during a home visit in March 2018. Miss X believed that the Health Board had recorded her concern as an Adult Safeguarding Referral (ASR), which it had passed to the Local Authority for consideration. Miss X complained that she had not received the outcome of the ASR.

Following discussions with both the Health Board and the Local Authority, the Ombudsman found that the ASR had been misplaced. However, he could not establish how this had occurred, or which body was at fault. The Ombudsman acknowledged Miss X's confirmation that she had had no further contact with the member of staff concerned. The Ombudsman found (and Miss X accepted) that it was no longer practical for the ASR to be considered due to the length of time which had passed.

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

- 1) Provide a written response to Miss X regarding the concerns raised in her letter to the Health Board dated 9 September 2018.
- 2) Provide a redress payment of £250 in recognition of the distress caused to Miss X by the delay in handling her concern.
- 3) Carry out the above actions within 30 working days from the date that the Ombudsman issues his decision.

Cardiff and Vale University Health Board – Health

Case Number: 201903165 – Report issued in September 2019

Mr X complained that he had been told that an Independent clinician's report into the care he received, which was agreed as a result of a complaint he made to the Ombudsman, was to be provided by within 10 weeks of 22 January 2019. However Mr X complained that in September 2019 he still had not received the independent Clinician's report.

The Ombudsman found that due to a number of circumstances that appeared to be beyond the control of the Health Board such as the personal circumstance of the Independent Clinician. The Report had not been provided. However, at the time of the Ombudsman's enquiries, the Health Board expect to receive the Independent Clinician's report soon.

The Ombudsman therefore agree with the Health Board, that by 6 October 2019 it would:

- a) Provide Mr X with the complete Independent Clinical Adviser's report.
- b) Provide Mr X with an apology and a specific explanation for the delay in providing the report.

Education

Upheld

[Neath Port Talbot Council - Special Educational Needs \(SEN\)](#)
Case Number: 201802109 – Report issued in September 2019

Ms B complained that Neath Port Talbot Council, acting as the Local Education Authority in respect of the provision of education for her son (“C”), failed to assess his educational needs in a timely manner and did not deal with her complaints properly and in accordance with its complaint policy. The Ombudsman was restricted from considering any complaints about the actions of the schools involved.

The investigation found that although C was receiving additional support from the Council at the schools he attended, it was usually for the schools to determine whether progress was adequate and whether a statutory assessment should have been considered. There was no evidence to suggest that the Council had been asked to determine whether a statutory assessment was appropriate or that the Council could reasonably have been expected to consider that one was necessary given the reassurances from the schools regarding C’s progress. The Ombudsman did not uphold this part of Ms B’s complaint.

Ms B complained to the schools concerned and the Council carried out an investigation on the behalf of the schools. The Council conducted the investigation in a timely fashion but the process remained under the control of the school and there were subsequent delays in addressing Ms B’s concerns. The Council did not make clear to Ms B, at the outset, the limit of its role in the complaint handling. This caused Ms B confusion and distress as she believed the Council was handling her complaint when it was not the body responsible. The Ombudsman partially upheld Ms B’s complaint about the complaint handling and the Council agreed to the Ombudsman’s recommendation that it should apologise for not explaining the limit of its role.

Not Upheld

[Wrexham County Borough Council - School Transport](#)
Case Number: 201804852 – Report issued in August 2019

Mr A was a foster carer with a private foster care agency (“the Agency”) through a placement arranged by the Agency, he looked after child G on behalf of the Council. Mr A complained that the Council had gone back on an agreement to provide school transport before 8.00am to get child G to school on time. He also said that the Council had failed to provide appropriate assistance to help him meet child G’s educational needs. Although the Council had offered alternative arrangements that would allow child G to attend school on time, Mr A was not in agreement with them.

The Ombudsman found that the Council had met with its statutory obligation to provide free school transport for child G. Having made extensive enquiries with both the Council and the Agency, there was no evidence to support that the Council had agreed to provide school transport for child G before 8.00am. The Ombudsman could not reach a finding about the appropriateness of alternative arrangements proposed by the Council as they had not been finalised. However, under the terms of the Council's contract with the Agency, it fell to the Agency to facilitate child G's attendance at her educational placement. Therefore, it was a matter for the Agency and not the Council to have assisted Mr A further in enabling child G to get to school on time. Mr A's complaints were not upheld.

Early Resolution or Voluntary Settlement

[Admissions Appeal Panel - The Bishop of Llandaff Church in Wales High School - Admissions procedures and appeals](#)

Case Number: 201901389 – Report issued in August 2019

Mr H complained that the Appeal Panel had failed to overturn a decision that his son should not be offered a place at the School. He said that he had been misled about the admissions process for the school, including its oversubscription criteria and questioned whether those criteria had been applied properly.

The Ombudsman agreed with the Appeal Panel that the School's published admission arrangements were proper and lawful, and that they had been correctly and impartially applied to Mr H's application. However, he found that the Appeal Panel's decision letter was overly generic and inadequate to explain how it had balanced the degree of prejudice to the school if Mr H's son were to be admitted against the weight of the Mr H's appeal submission and mitigating factors.

The Appeal Panel agreed to write to Mr H again, to apologise for the brevity of its initial decision letter and to provide a more detailed explanation of its decision. It also undertook to suggest to the School and the Admissions Committee that the admissions criteria should be made absolutely clear in the published literature, to prevent any misunderstanding or misinterpretation of the process.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

[Cardiff Council - Refuse collection. recycling and waste disposal](#)

Case Number: 201901604 – Report issued in July 2019

Mr X complained about the Council's Waste Management Team's failure to return his mother's refuse bin to the compound correctly and close the secure gate. Mr X had made a number of complaints regarding the issue but had yet to receive a response and a permanent solution.

The Ombudsman was concerned that Mr X clearly felt let down by the Council and therefore considered it appropriate that Mr X should receive some reassurance that measures are being taken to lessen the likelihood of this happening again. The Council accepted that this was unacceptable and agreed to undertake the following action, in settlement of the complaint, within one month of the date of the Ombudsman's decision letter:

- a) Clarify which team is responsible for ensuring the refuse bin is returned to the compound correctly and the secure gate is closed.
- b) Issue a fuller response to Mr X explaining what changes have been put in place to ensure it will not happen again.
- c) For the Waste Management Team to review how both the Housing Clearance Team and Waste Management Team will work together to prevent reoccurrence.

Noise and other nuisance issues - Ceredigion County Council Case Number: 201903084 – Report issued in September 2019

The Ombudsman found that, although the Council had followed its procedure for investigating the noise nuisance complaint, it had also undertaken remedial works to a neighbouring property in an effort to reduce the noise. These works were undertaken outside of its usual procedure and Mr A alleged that they had caused damage to his property. Additionally, the Council had failed to provide Mr A with sufficient information about its procedure, there were some communication failings, and the Council's complaint response failed to fully address one area of concern.

In recognition of the failings identified, the Council agreed to undertake the following in settlement of the complaint by 28 October 2019:

- a) Assess the alleged damage to Mr A's property and, if it does not consider it is responsible, provide information to Mr A on how to pursue an insurance claim against the Council.
- b) Apologise to Mr A for the communication failings identified.
- c) Publish the noise nuisance investigation procedure on its website and review its noise nuisance acknowledgement letters.
- d) Make a redress payment of £125 to Mr A for the time and trouble in making his complaint to the Ombudsman.

Conwy County Borough Council - Noise and other nuisance issues Case Number: 201902684 – Report issued in September 2019

Ms W complained that the Council had failed to carry out an adequate investigation into a noise nuisance complaint. She was unhappy that the Council had not identified the source of the noise and had not informed her about the ongoing status of the investigation. The Ombudsman was satisfied that the Council had complied with its obligations in regard to the extent of the investigation. He was concerned, however, that the Council had not notified Ms W that the investigation had been discontinued and had not provided her with reasons for its decision. Following discussions with the Ombudsman, the Council agreed the following actions:

- 1) Provide Ms W with a written account of the investigations undertaken into the source of the noise, including full details of the measures taken to investigate each potential source of the noise and an explanation of the decision to discontinue the investigation.
- 2) Offer Ms W a meeting to be held within the next 6 weeks to discuss the investigation in more detail.

The Ombudsman considered these actions to represent an appropriate resolution to the complaint.

Finance and Taxation

Early Resolution or Voluntary Settlement

Cardiff Council - Finance and Taxation

Case Number: 201903159 – Report issued in September 2019

Mr X complained about the Council's decision to remove the reduction to his Council Tax liability which he had previously been entitled to, leaving him with an unexpected bill of over £800. The Ombudsman found that the Council had failed to advise Mr X of his right to appeal against the decision to the Valuation Tribunal Wales. In response to the Ombudsman's enquiries, the Council decided, as a gesture of goodwill, to clear Mr X's outstanding bill. The Council also agreed to, within 20 working days, apologise to Mr X for failing to advise him of his appeal rights and to remind relevant staff of the need to do so when issuing such decisions.

The Ombudsman considered these actions were reasonable in settlement of the complaint.

Housing

Early Resolution or Voluntary Settlement

Cardiff Community Housing Association - Tenancy rights and conditions/abandonment and evictions

Case Number: 201901276 – Report issued in July 2019

Mr X complained that the Association had failed to clean the windows on his property. Mr X is a tenant with the Association, and it is supposed to ensure that the building is kept clean however they were not adhering to this.

The Association said the windows are cleaned on a quarterly basis and it agreed to complete the following in settlement of Mr X's complaint:

By 30 June 2019

- a) The windows to be cleaned and completed over a period of 5 working days. (We believe this has now been completed)

By 30 September 2019

- b) The windows to be cleaned and completed over a period of 5 working days (weather dependent).

United Welsh Housing Association - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number: 201901591 – Report issued in July 2019

Miss X complained that the Association had failed to repair her boiler and had left her without heating since February 2019 despite being told it would only take 6-8 weeks.

Miss X said there was a complete lack of communication and the Association had not kept her updated on the progress of the repair.

It had also failed to compensate her for the loss of heating.

The Ombudsman considered this to be a service failure on the part of the Association. The Association therefore agreed to complete the following in settlement of Miss X's complaint:

By 9 August 2019

- a) Complete all repairs to the boiler

Within 14 working days

- b) Apologise to Miss X for the length of time it has taken for it to reach a resolution regarding her boiler
- c) Make a payment of £667.50 to Miss X for the time and trouble of making of her complaint to the Ombudsman and for the numerous failures on its part

The Association has also said it will be investigating why there was such a lack of communication to ensure that this does not happen again.

Powys County Council - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number: 201903016 – Report issued in August 2019

Mrs X complained that the Council's Housing Department had failed to make a full redecoration allowance payment to her or compensate her for delays her mother, Mrs Y, had experienced in the Council undertaking repairs to her home. Mrs X also complained that the Council had promised to apologise to her mother but had failed to do so.

The Ombudsman found that the Council had made a £250 payment to Mrs X as a result of its own investigation into her complaint, but there was a lack of clarity as to the reasons it had made the payment. Additionally, the Council had promised to write directly to Mrs Y to apologise to her, but no apology had been made.

Therefore, in settlement of the complaint, the Council agreed to complete the following actions by 18 September 2019:

- a) Apologise directly to Mrs Y (as previously promised), offering a further apology for the delay in writing to her
- b) Apologise to Mrs X for the lack of clarity regarding the £250 payment it had made
- c) Explain to Mrs X what the £250 payment entailed.

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

[Case Number: 201902645 – Report issued in August 2019](#)

Mr X complained that Cardiff Council (“the Council”) had not fully responded to the complaint he made to it in May 2019. Mr X then made a further request to it via email in June 2019, but received no response.

The Council agreed to undertake the following in settlement of Mr X's complaint:

By 11 September 2019:

- a) Issue Mr X with a substantive response to his outstanding concerns.
- b) Offer Mr X a gesture of good will payment of £25.00 for the inconvenience and delay in its response.

The Ombudsman considered this to be an appropriate resolution to the complaint.

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

[Case Number: 201804610 – Report issued in August 2019](#)

The Complainant complained that there were unacceptable delays by her landlord, Powys County Council, in taking action to address a damp problem in her home. She was also concerned that the Council had not refunded her redecoration costs.

The Ombudsman found that there was evidence to suggest some unnecessary delays on the part of the Council's contractors in carrying out works to address the damp problem and therefore proposed a settlement to resolve the matter.

The Council agreed to pay the Complainant financial redress of £625 to reflect the delays which had occurred in the works being completed, the redecoration costs and damage to the Complainant's possessions. It would also liaise with the Complainant to agree a mutually convenient time for the remaining works to be inspected and signed off.

Coastal Housing Group Ltd - Neighbour disputes and anti-social behaviour Case Number: 201902820 – Report issued in September 2019

Ms H complained that the Association had failed to provide a parking space to her, and had not dealt with anti-social behaviour issues she had experienced with her neighbour.

The Ombudsman found that Ms H's property was not listed in the housing scheme's specification as having a designated parking space, and that the Association had attempted to facilitate an agreement between Ms H and her neighbour for her to park in his space.

However, as Ms H's complaint to the Ombudsman alleged anti-social behaviour on behalf of her neighbour, and Ms H said she was experiencing difficulties with her disability as she was not able to park near her property, the complaint was settled on the basis that the Association would complete the following actions by 2 October 2019:

- a) Write to Ms H to offer mediation with her neighbour
- b) Offer a meeting to Ms H to discuss the possibility of a transfer to a property with a designated parking space.

The Ombudsman also found that the Association had agreed to make a payment to Ms H in reimbursement of a lock she had purchased, but had failed to do so. The Association therefore also agreed to complete the following by 2 October 2019:

- c) Reimburse Ms H for the cost of the lock, as previously promised.

Cartrefi Conwy - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing) Case Number: 201902316 – Report issued in September 2019

Ms A complained that the Association led her to believe that it would install her gas cooker when she moved into the property. When she moved into the property she was advised that there was no gas facility in the property and she would have to arrange to have a gas connection installed at her own expense.

The Ombudsman found that the Association failed to provide Ms A with the information required prior to agreeing to move into the property.

The Association has now undertaken the following actions: -

- 1) Apologised to Ms A for providing her with incorrect information.
- 2) Installed the gas cooker.
- 3) Arranged a visit to discuss outstanding concerns and offer a £100 voucher as a goodwill gesture.

The Association has also agreed to: -

- 4) Review the information provided to tenants and update its handbook **by 30 September 2019**.

Cardiff Community Housing Association - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)

Case Number: 201903207 – Report issued in September 2019

Mr X complained that Cardiff Community Housing Association (“the Association”) had not removed foliage which is encroaching on Mr X’s boundary wall.

The Association agreed to undertake the following in settlement of Mr X’s complaint:
By 26 September:

- Arrange for contractors to attend Mr X property to remove the foliage.

The Ombudsman considered this to be an appropriate resolution to the complaint.

Cardiff Council - Applications. allocations. transfer and exchanges

Case Number: 201902469 – Report issued in September 2019

Mrs X complained that the Council would not allow her to be added to her mother’s tenancy agreement and failed to take into consideration her personal circumstances when it made its decision.

Although the Council had responded to Mrs X’s complaint, the letter was vague and lacking in detail. The Council agreed to the following in settlement of Mrs X’s complaint:

By the end of September 2019

- a) Provide a detailed letter to Mrs X fully explaining the decision it made.

Planning and Building Control

Early Resolution or Voluntary Settlement

Pembrokeshire County Council - Other planning matters

Case Number: 201903126 – Report issued in September 2019

Mrs X complained, that following planning approval a year ago for a scrap yard at her neighbour’s property, her neighbour has exceeded the allowed boundary and was parking scrapped vehicles on Council land, which Mrs X said was unsightly.

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

By 10 October:

- Arrange a face to face meeting with Mrs X and representatives from each of the relevant departments (Planning, Highways, Parking and Abandoned Vehicles) to discuss what is going on and what measures each department can/cannot take.

The Ombudsman considered this to be an appropriate resolution to the complaint.

Flintshire County Council - Unauthorised development - calls for enforcement action etc
Case Number: 201903049 – Report issued in September 2019

Mr X complained that Flintshire County Council failed to take enforcement action against a neighbouring property. Mr X also complained that Flintshire County Council provided him with incorrect information in a stage 2 complaint response issued to him.

The Ombudsman found that the Council had failed to provide Mr X with a fixed timescale as to when enforcement action against his neighbouring property would be commenced. Additionally, the Ombudsman found that the Council had given Mr X incorrect information in their stage 2 complaint response and had failed to provide him with an accurate and comprehensive update in regard to his complaint.

The Ombudsman contacted the Council and it agreed to:

- a) Provide Mr X with a written apology for the incorrect information provided to him in their stage 2 complaint response.
- b) Provide Mr X with a full, accurate and comprehensive update regarding his complaint.
- c) Complete the preparatory work for enforcement action and issue it, if necessary, within an agreed timescale.

The Ombudsman was satisfied that this would provide a resolution to the issues considered in this complaint.

Roads and Transport

Upheld

Brecon Beacons National Park Authority - Road maintenance/road building
Case Number: 201806171 – Report issued in September 2019

Mr N complained about matters arising from a long-running dispute with the Authority. In particular he complained about:

- a) The failure of the Authority to warn him against carrying out work he informed them he intended to undertake, and which it later said was unauthorised.
- b) The delay in the Authority's response to his complaint, along with the involvement of the Chief Executive (who, in his previous role in the Authority was the subject of Mr N's complaint) in the production of the investigation report.
- c) The actions taken by the Authority to implement the recommendations of the report.

The Ombudsman found that the Authority had failed to ensure the work Mr N intended to carry out was clear and, if necessary, agreed in advance. This amounted to maladministration. The investigation of Mr N's complaint by the Authority had taken in excess of 3 years, and involved at least 13 versions of the Investigating Officer's report. It was clear that some of the wording in the report had been influenced by the Chief Executive's comments on some of the versions. The Ombudsman also found that, although accepted by the Authority, not all the recommendations of the Investigating Officer had been implemented promptly. The Ombudsman upheld all elements of the complaint.

The Ombudsman recommended that the Authority apologise to Mr N, pay him a total of £1250 to reflect the time and trouble in pursuing his complaint and the distress and inconvenience caused by the failings identified. He also recommended the Authority keep Mr N updated on its actions to implement the Investigating Officer's recommendations. The Authority agreed to carry out the Ombudsman's recommendations.

Early Resolution or Voluntary Settlement

Vale of Glamorgan Council – Other

Case Number: 201901789 – Report issued in July 2019

Mr X complained that the Council relocated a bus stop outside his front door. He stated this relocation occurred without a formal impact assessment and furthermore, residents did not receive any notice from the Council alerting them to the relocation of the bus stop.

The Council had since, indicated that they would find an alternative location nearby to relocate the bus stop but had failed to do so.

The Council have now confirmed that a decision has been made to relocate the bus stop and have agreed to the following in settlement of Mr X's complaint

Starting 3 July 2019

- a) Work will commence with the relocation of the bus stop flag sign and post back to its original location.

Over the following days

- a) The bus stop kerbs will be removed and replaced with standard kerbs.

Welsh Government – Other

Case Number: 201901943 & 201901940 & 201901939 & 201901937 – Report issued in July 2019

Mr X complained about delay in finalising the compulsory purchase of his clients' land by Welsh Government, as a result of which he was unable to plan for the future.

Whilst Welsh Government said that the process is complex, it accepted that a number of issues had impacted on the prioritisation given to the compulsory purchase order.

Welsh Government agreed to attempt to complete the work to finalise the compulsory purchase order by 15 October. If this was not possible, it agreed to provide a substantive explanation for the delay together with supporting evidence and an up to date timescale for completion to the Ombudsman's office.

Cardiff Council – Other

Case Number: 201903155 – Report issued in September 2019

Mr X complained that Cardiff Council (“the Council”) had removed a No Through Road Sign near his home. Mr X had complained to the Council over a number of years and received assurances that the request for new signage would be implemented, however, the Council had still not replaced the sign.

In settlement of Mr X's complaint, the Council agreed to replace the No Through Road Sign by 11 October 2019.

Self-funding Care Provider

Early Resolution or Voluntary Settlement

Conwy County Borough Council - Domiciliary Care

Case Number: 201902693 – Report issued in August 2019

Ms A complained that following a welfare benefit assessment she was not informed by the Council that it would set up a domiciliary care package for her nor that she would need to financially contribute to that package before it was in place. Ms A said when she became aware of this, she cancelled the care package but the Council maintain she is liable for the fees incurred prior to cancellation despite her not giving the Council prior consent to make such arrangements.

Before investigating a complaint, the Ombudsman must be satisfied that the matter(s) complained have been raised with the body concerned and that it has had a reasonable opportunity to investigate and respond. Local authorities in Wales have a statutory complaints procedure for social services complaints which is governed by The Social Services Complaints Procedure (Wales) Regulations 2014. Whilst the Council dealt with Ms A's request to waive the outstanding fees appropriately, namely via its internal appeals process, it had not dealt with the crux of the complaint. Namely, that Ms A was not previously informed nor previously gave consent to the Council, to set up a domiciliary care package prior to it being put in place.

The Ombudsman contacted the Council and it agreed to put Ms A's complaint through its statutory social services complaints procedure.

Social Services – Adult

Upheld

Conwy County Borough Council – Other

Case Number: 201800208 – Report issued in July 2019

Mr A complained that the Council's Social Services Department had failed to provide direct payments (“DPs”) at an amount that met his family's assessed need for respite care. He said that this left him unable to pay his care workers a lawful wage. He also complained about the Council's handling of his complaint. Mr A said that he lost his care workers because of the Council's failure to take prompt action to put matters right putting his family under an intolerable strain.

The Ombudsman found that the Council had failed to follow Welsh Government guidance on calculating the proper costs associated with the services that Mr A's family needed. Although the Ombudsman did not find that Mr A had lost his care workers as a direct result of the Council's actions, there was evidence of an unresolved wage dispute. The Ombudsman also found that the Council's investigation of Mr A's complaint was not robust and that the remedial action it had taken failed to put matters right, either for him or his former employees.

The Council agreed to offer a fulsome apology and financial redress of £750 to Mr A in recognition of the impact of these failings in addition to ensuring that any outstanding DP arrears were paid with interest.

Torfaen County Borough Council - Services for older people
Case Number: 201801395 – Report issued in September 2019

Ms B complained about the social care provided to her mother Mrs C. Ms B complained that the Council did not follow the correct processes when it changed care plans or when undertaking a Protection of Vulnerable Adults (POVA) investigation. Ms B complained that the Council failed to provide her with important information when changing the care plans and when making an application to the Court of Protection. Ms B also complained that the Council did not properly apply its Unacceptable Actions Policy (UAP) and did not properly manage her complaints.

The investigation found the Council considered relevant information when making decisions about care plans including balancing the safety of Mrs C and her support workers. Therefore, the complaint about the care plans, which formed the substantive part of the investigation, was not upheld. The investigation found that, largely, the Council managed the POVA process appropriately but that there had been some delays caused by a lack of guidance on cross-border cases and this caused a limited injustice to Ms B; this complaint was upheld to a limited extent.

Ms B's complaint about the failure to provide her with important information was partly upheld. The investigation found that even though there was an ongoing dialogue between the Council and Ms B, on occasion, communication could have been better. The Council had already apologised for this. Ms B's complaint about the UAP was also partly upheld as the Council failed to recognise a request to appeal the decision to impose it; the investigation found that this caused Ms B further frustration. The complaint that the Council did not properly manage Ms B's complaints was not upheld.

The Council agreed to apologise for the failings identified in the report and to brief complaint handling staff on the importance of recognising when an appeal is being sought. The Council also agreed to liaise with the Adult Safeguarding Board to ask it to consider providing guidance on the management of cross border POVA complaints.

Early Resolution or Voluntary Settlement

Gwynedd Council - Services for vulnerable adults (eg with learning difficulties, or with mental health issues)
Case Number: 201901008 – Report issued in July 2019

Miss H complained that the Council failed to manage her expectations about the length of time its Community Mental Health Team ("CMHT") would take to complete an assessment and care plan and said this caused additional and unnecessary distress to her.

The Ombudsman found that, whilst the Council had not upheld Miss H's complaint, it had agreed to review the information it provided to service users at the point of CMHT intervention.

In responding to the Ombudsman's enquiries, the Council agreed to complete the following actions by 14 August 2019 in settlement of Miss H's complaint:

- a) Apologise to Miss H if she had not been informed of the assessment timescales and for any distress caused by this
- b) Feedback to relevant CMHT staff the need to provide information regarding assessment timescales to service users.

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

[Case Number: 201807449 – Report issued in August 2019](#)

Mr T complained that, during the time his mother was resident at a Care Home between 31 January and 21 March 2018, she did not receive adequate and appropriate care to meet her needs in relation to her level of hydration, her deteriorating mobility and risk of falls. He also complained that Care Home staff failed to ensure appropriate medical review of his mother's recurrent urine infections.

During the course of the investigation, Mr T asked the Council to initiate a Stage 2 Investigation, under the Social Services Complaints Procedure, in relation to a number of other issues from the same time period relating to the care his mother received at the Care Home. The Council agreed that the Stage 2 Investigation would consider seven issues that Mr T had listed and the three issues that the Ombudsman had agreed to investigate. It agreed that the final Stage 2 response would be issued by 7 October 2019. The Ombudsman considered this to be a reasonable settlement and concluded the investigation on that basis.

Social Services – Children

Early Resolution or Voluntary Settlement

[Powys County Council – Other](#)

[Case Number: 201807158 – Report issued in July 2019](#)

Ms X complained about the Council's delays and failure to implement all the recommendations in the Council's stage two investigation reports dated July 2018 and January 2019, which were to address her social services complaint about the way it handled her granddaughter's, Y, case.

The Council accepted the findings of the two Independent Investigator's stage two reports and said it had agreed to implement all the recommendations made, but acknowledged its delays in doing so. The Council said some of the delay was outside its control, such as missing social services records for Y, and this had led to delays in its implementation of the recommendations. The Council confirmed that it has recently located some of Y's previously missing social services records relevant to Ms X's substantive complaint.

In settlement of Ms X's complaint to this office, the Council agreed to apologise to Ms X and offer her a financial redress payment for the delays she experienced and her time and trouble taken to try to resolve her substantive complaint with the Council. The Council also agreed to refer Ms X's complaint back to the stage two Independent Investigator to consider the previously missing social services records for Y and to prepare an accurate account to be placed in Y's social services record of how she came to live with Ms X. Finally, the Council agreed to update the recommendations made in its previous stage two report.

Cardiff Council – Safeguarding

Case Number: 201901799 – Report issued in August 2019

Mrs A, despite having complained to the Council, still felt that her concerns against Social Services had not been properly addressed. She felt that a 'local resolution' type meeting with the Council where the attendees included key personnel involved in her case would be beneficial.

In settlement of Mrs A's complaint, the Council agreed to the 'local resolution' meeting and agreed to action it by 30 September 2019.

Caerphilly County Borough Council - Social Care Assessment

Case Number: 201807245 – Report issued in August 2019

Mr E complained about the service Caerphilly County Borough Council provided regarding his son's care and support needs, and the way it handled his complaint. Mr E said the Council initially declined his request for a formal investigation of his concerns and subsequently failed to act with any urgency in response to an independent investigation report, specifically concerning a multi-agency assessment for his son. Mr E said as a result his family was going without the support it needed.

While the Council provided information to the Ombudsman to confirm a multi-agency assessment and care and support plan had since been implemented, the Ombudsman found shortcomings in the Council's initial response to Mr E's complaint, and that the delay in carrying out actions in response to the independent report had caused frustration for Mr E and his family.

The Ombudsman sought the Council's agreement to pay Mr E redress of £500 for the time and trouble taken in making his complaint, and the frustration caused by the delays encountered. The Council also agreed to arrange a meeting with Mr E and multi-agency staff to discuss Mr E's concerns regarding his son's multi-agency assessment and care and support plan.