

The Ombudsman's Casebook

Issue 39 October – December 2019

News

Ombudsman Welcomes Health and Social Care Bill

In September, the Ombudsman appeared in front of the Health, Social Care and Sport Committee to give evidence on the Health and Social Care (Quality and Engagement) (Wales) Bill.

He welcomed the bill and its aspirations to drive improvements in the quality of the care the NHS delivers to patients.

New Complaints Standards Authority To Be Launched

In preparation for the launch of the Complaints Standards Authority, Head of Complaints Standards, Matthew Harris and Training and Support Officer, Tanya Ffello, visited contact officers at 18 different local authorities across Wales to discuss new arrangements.

For more information on the Complaints Standards Authority e-mail: csa.data@ombudsman.wales

* Following a boundary review, from 1 April 2019, the former Abertawe Bro Morgannwg University Health Board was renamed Swansea Bay University Health Board, to reflect the provision of healthcare services in the Swansea and Neath Port Talbot Areas and the transfer of responsibility for the provision of healthcare services in the Bridgend area (including the Princess of Wales Hospital) to the former Cwm Taf University Health Board, which was renamed Cwm Taf Morgannwg University Health Board

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Health

Upheld

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

Case Number: 201807546 – Report issued in October 2019

Mrs B complained that the Health Board took an unreasonable amount of time to respond to her complaint and failed to follow either the statutory complaints process or its own complaints procedure. The complaint was upheld. The investigation found significant delays by the Health Board in the handling of the complaint and that it undertook an additional step in its consideration of the complaint that was not in accordance with its written procedure. The investigation also found that the Health Board's complaint responses were not clear and did not contain all of the statutorily required information. The Ombudsman found that this caused avoidable distress to Mrs B.

The Health Board agreed to apologise for the failings identified and to review its procedure to ensure it reflected current practice.

[Powys Teaching Health Board - Patient list issues](#)

Case Number: 201804730 – Report issued in October 2019

Powys Teaching Local Health Board ("the First Health Board") has commissioned Aneurin Bevan University Health Board ("the Second Health Board") to provide healthcare to some of its residents. Mr A complained the Second Health Board had incorrectly applied the referral to treatment waiting times rules ("RTT rules") when he had an operation on his hand causing his knee replacement operation to be delayed. Mr A was also dissatisfied with the Second Health Board's complaint handling and the robustness of its complaint response.

The Ombudsman's investigation found that the Second Health Board had failed to provide sufficient patient information about the RTT rules and the Second Health Board's processes on medical fitness when a patient has sequential surgical procedures. This meant Mr A was not in a position to make an informed choice when he decided to proceed with a minor hand operation which could have waited until after his knee replacement operation. The Ombudsman concluded that this caused Mr A an injustice as it led to his knee operation being delayed. In addition, the Ombudsman found that the Second Health Board's complaint response erroneously explained aspects of the RTT rules which was not helpful.

The Ombudsman recommended that the Second Health Board should apologise to Mr A for the failings, develop a clear and accessible patient information leaflet on the RTT rules in this area and put in place administrative processes to address record keeping and process shortcomings. In addition, both the First Health Board and the Second Health Board should discuss Mr A's case in their next quarterly Commissioning Quality, Performance and Review meeting with the focus being on learning lessons.

[Aneurin Bevan University Health Board - Patient list issues](#)

Case Number: 201803799 – Report issued in October 2019

Powys Teaching Local Health Board ("the First Health Board") has commissioned Aneurin Bevan University Health Board ("the Second Health Board") to provide healthcare to some of its residents. Mr A complained the Second Health Board had incorrectly applied the referral to treatment waiting times rules ("RTT rules") when he had an operation on his hand causing his knee replacement operation to be delayed. Mr A was also dissatisfied with the Second Health Board's complaint handling and the robustness of its complaint response.

The Ombudsman's investigation found that the Second Health Board had failed to provide sufficient patient information about the RTT rules and the Second Health Board's processes on medical fitness when a patient has sequential surgical procedures. This meant Mr A was not in a position to make an informed choice when he decided to proceed with a minor hand operation which could have waited until after his knee replacement operation. The Ombudsman concluded that this caused Mr A an injustice as it led to his knee operation being delayed. In addition, the Ombudsman found that the Second Health Board's complaint response erroneously explained aspects of the RTT rules which was not helpful.

The Ombudsman recommended that the Second Health Board should apologise to Mr A for the failings, develop a clear and accessible patient information leaflet on the RTT rules in this area and put in place administrative processes to address record keeping and process shortcomings. In addition, both the First Health Board and the Second Health Board should discuss Mr A's case in their next quarterly Commissioning Quality, Performance and Review meeting with the focus being on learning lessons.

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

[Case Number: 201807103 – Report issued in October 2019](#)

Ms R complained about the failure to administer an adequate dose of anaesthetic prior to her caesarean section. Ms R said that the checks carried out were not thorough enough to ascertain whether the anaesthetic administered to her was sufficient. She also said that the clinical team dismissed her concern that the anaesthetic was not effective and that she was still experiencing pain and continued to do so during the caesarean section. Ms R also complained about the Health Board's handling of her complaint.

The Ombudsman's investigation found that Ms R was administered an appropriate dose of anaesthetic. He also found that when Ms R complained of pain the clinical team listened to her concerns and offered Ms R the option of having the caesarian section performed under general anaesthetic which Ms R declined. As an alternative Ms R was given additional pain relief. The Ombudsman was satisfied that Ms R's care and management was reasonable and appropriate and therefore did not uphold this aspect of Ms R's complaint.

In relation to Ms R's concerns about the Health Board's handling of her complaint, the Ombudsman was pleased to note that the Health Board acknowledged that there was a delay responding to Ms R's complaint, and in recognition of the distress that this caused to Ms R offered her a redress payment of £250. Given the administrative shortcoming, this aspect of Ms R's complaint was upheld.

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

[Case Number: 201803090 – Report issued in October 2019](#)

Mrs A complained about the treatment and care provided to her late father, Mr B, during an admission to the Royal Gwent Hospital when he fell and sustained a hip fracture. Specifically, Mrs A raised concerns about the Health Board's assessment of Mr B's risk of falls, his treatment immediately following the fall, and its subsequent falls investigation. Mrs A also raised concerns around inadequate monitoring of Mr B's nutrition and continence needs, poor communication, and poor complaint handling.

The Ombudsman found that aspects of Mr B's nursing care did not meet a reasonable standard. The Health Board failed to assess Mr B's risk of falls in line with its Falls Policy exposing him to risk. There was also inadequate assessment and planning to meet Mr B's continence and nutritional needs compromising his dignity and resulting in significant weight loss that was not addressed. Although there was inadequate assessment of Mr B's head injury after his fall, there was no evidence of any acute complication. The Ombudsman also found that the Health Board's review mechanism for reducing in-patient falls was not robust as it had failed to identify any deficiencies in the application of the Falls Policy in Mr B's case. Aspects of the Health Board's communication with Mr B's family were found to be poor and it failed to respond to Mrs A's complaint in accordance with the NHS Complaints Procedure.

The Ombudsman recommended that the Health Board apologise to Mrs A and pay her £1000 for the

failings identified. It also agreed to share the learning from the complaint with relevant staff and to review whether further training on key nursing assessments was required. Finally, the Health Board agreed to review its nursing audit tools and falls investigation process to ensure their effectiveness.

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

[Case Number: 201800903 – Report issued in October 2019](#)

Mrs B complained about the care given to her husband, Mr B, by Aneurin Bevan University Health Board. She expressed concern about the Health Board's management of Mr B's falls risk, its treatment of his arm fractures following a fall and its physiotherapy provision after his discharge from hospital.

The Ombudsman found that the Health Board had managed Mr B's falls risk appropriately. He did not uphold the falls risk management element of Mrs B's complaint. He noted that the amount of physiotherapy which Mr B had received whilst in the community had been less than that which had been recommended for him. However, he could not determine that the functioning of Mr B's right arm and hand had been compromised by that deficiency. He did not uphold the physiotherapy part of Mrs B's complaint. He found that the Health Board had not enabled Mr B to make an informed decision about the surgical treatment of one of his arm fractures. He concluded that Mr B had not been given the opportunity to have timely surgery, which was likely to have resolved his right arm and hand problems, albeit in part, as a result. He upheld the surgical aspect of Mrs B's complaint.

He recommended that the Health Board should apologise to Mr and Mrs B for the failing identified. He asked it to pay Mr B £1000 in recognition of the uncertainty surrounding the possibility that the outcome for him, in terms of his right arm and hand function, might have been better if the Health Board had enabled him to make an informed decision about surgical treatment. He also recommended that the relevant clinicians should have a supervisory discussion about the surgical aspect of Mrs B's complaint and his related finding. The Health Board agreed to implement these recommendations. It also said that it would investigate the surgical aspect of Mrs B's complaint further if Mr B wanted it to do this.

[Crescent Dental Care - Clinical treatment outside hospital](#)

[Case Number: 201804893 – Report issued in October 2019](#)

Ms A complained about her treatment by the Practice over a two month period in 2018. Ms A underwent initial treatment (two fillings) performed by one of the dentists ("the First Dentist"). She returned to the Practice weeks later in pain and saw another dentist ("the Second Dentist"), as an emergency patient. The Second Dentist told Ms A that she needed root canal treatment (RCT) or the tooth's extraction. The Second Dentist performed the first part of the RCT and Ms A was to return to see the First Dentist at a later date for its completion, as she was her patient. Ms A complained that the First Dentist could not have treated her properly at the time and threatened legal action demanding that she in future only see the Second Dentist. However, the Second Dentist would not agree to do so. Ms A also complained about the Practice's communication with her and the handling of her complaint.

The Ombudsman's investigation found that Ms A's clinical care was carried out to an appropriate standard and did not uphold the complaint. However, he upheld the communication aspect of Ms A's complaint, finding that it could have been better. Had it been, it might have avoided the complaint. The First Dentist's records were not as fulsome as those of the Second Dentist, leading the Ombudsman to conclude that the possibility of an RCT (which might lead the tooth to fracture later as it did, given it would be brittle) had not been discussed with Ms A. This led Ms A to believe that the First Dentist had not treated her properly - directly resulting in her complaint. The Practice's exchanges with Ms A could also have been better - including informing her of the right to bring her complaint to the Ombudsman (as required). This meant Ms A did not bring her complaint for many months, which was an injustice. However, the Practice was entitled to decide that the relationship between it and Ms A had broken down and that she could no longer be treated there.

The Ombudsman recommended that the Practice apologise to Ms A and offer her redress of £75 for the

communication failings identified. The First Dentist was also asked to reflect on the issue of making fulsome records of consultations as part of the records audit the Practice had already begun. The Practice agreed to implement the recommendations.

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

[Case Number: 201804925 – Report issued in October 2019](#)

Miss X complained about the care she received from the former Cwm Taf University Health Board (“the Health Board”). Specifically, Miss X complained that the Health Board did not appropriately investigate or treat the symptoms of arthrofibrosis, which she complained about in 2013. Miss X also complained that the Health Board did not handle her complaints properly.

On advice, the Ombudsman found that it was unlikely that Miss X had arthrofibrosis. He partially upheld the complaint that Miss X's symptoms were not treated or investigated properly, because Miss X had complained of pain from September 2013 but did not receive any treatment until at least November 2014. The Ombudsman also found that there were errors in the way the Health Board handled Miss X's complaint.

The Ombudsman recommended that Cwm Taf Morgannwg University Health Board (as it now is) apologises to Miss X for the delay in treatment of the pain in her knee and for the errors in complaints handling. He also recommended that the Health Board offers Miss X a redress payment of £500, and undertakes training of the Complaints Department on when medical records may be amended.

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

[Case Number: 201804633 – Report issued in October 2019](#)

Mrs A complained about the orthopaedic care and treatment that she received from the Health Board. Mrs A complained that the Orthopaedic Consultant failed to listen to her symptoms and incorrectly decided to treat her pain with steroid injections in the lumbar region. Mrs A also complained that scans should have been undertaken of the area in question prior to administering the steroid injections, and that the steroid injections caused acute sciatic pain which was not appropriately managed.

The investigation found that the decision to treat Mrs A's pain with steroid injections had been reasonable, and that in the circumstances an additional scan was not clinically indicated; these elements of the complaint were not upheld. The investigation also found that the Consultant had failed to consider the later changes in Mrs A's symptoms and consider whether further orthopaedic intervention was required. As a result, Mrs A continued to experience unexplained pain and felt that she had no choice but to seek a second opinion. This element of the complaint was partly upheld.

It was recommended that the Health Board apologise to Mrs A and that the relevant clinicians consider the report during their next appraisal so that any lessons may be identified and shared.

[Cross Hands Health Centre - Clinical treatment outside hospital](#)

[Case Number: 201900162 – Report issued in November 2019](#)

Dr A complained about the care and treatment provided to his late mother, Mrs B, by a GP Practice in the area of Hywel Dda University Health Board. Specifically, Dr A complained that a GP at the Practice failed to appropriately assess Mrs B's symptoms during a telephone consultation and thereafter provide adequate medical treatment. Additionally, Dr A complained that the Practice failed to address his concerns and provide reassurance that lessons had been learned.

The Ombudsman found that the telephone consultation with Mrs B was not conducted to an appropriate standard. The GP did not have sufficient information to justify a decision not to have a face to face consultation to diagnose and treat Mrs B's symptoms. As a result, Mrs B was not given the option of attending at the Practice for an examination. Additionally, the investigation found that Mrs B was not given follow up advice in the event that she continued to feel unwell. Finally, the investigation found that,

although the Practice had itself identified that the GP had not followed best clinical practice to assess Mrs B's symptoms, it did not convey the full extent of its considerations and conclusions in the complaint response provided to Dr A. Consequently Dr A was not reassured that lessons had been learned.

The Ombudsman recommended that the Practice apologise to Dr A for the failings identified. The Practice and the GP were asked to reflect on the lessons to be learned from the complaint.

[Ringland Medical Practice - Clinical treatment outside hospital](#) [Case Number: 201805231– Report issued in November 2019](#)

Mrs A complained about the GP's consultation with her mother, Mrs B, and the fact that the GP had prescribed an antibiotic (clarithromycin) alongside her mother's heart medication (amiodorone), despite her mother making it clear that this was not her usual antibiotic. Her mother subsequently suffered an adverse reaction which led to an inpatient admission with heart related complications. Mrs A was also dissatisfied with the GP Practice's handling of her complaint and the poor complaint response.

The Ombudsman's investigation identified clinical failings, particularly around the medication warning alert that would have flagged up the medications' severe adverse interaction. The Ombudsman also identified administrative failings around record-keeping. The Ombudsman concluded that this had caused Mrs B an injustice and upheld this part of Mrs A's complaint.

From a complaint handling perspective, the Ombudsman established that wider organisational failings had also contributed to the excessive delay and poor complaint handling and complaint response evident in Mrs A's case.

As a result of Mrs A's complaint and the Ombudsman's investigation, the GP and GP Practice had put in place measures to address the failings. Therefore, the recommendation in this case was limited to the GP and GP Practice making a fulsome apology to Mrs A and her mother for the failings.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201707331– Report issued in November 2019](#)

Mr A complained about the management of his wife's Crohn's Disease ("CrD") at Nevill Hall Hospital ("the Hospital") and in particular about delays in a colonoscopy report in August 2016 being considered. He also complained about delays in his wife being administered morphine during an inpatient admission and his wife not having her baby delivered sooner given her presenting signs of pre-eclampsia and reduced foetal movements. Finally, Mr A was dissatisfied with the robustness of the Health Board's complaint response.

Broadly, the Ombudsman's investigation concluded that Mrs A's gastroenterology care was not as integrated, effective and patient-centred as it could have been. As a result this caused Mrs A an injustice and to that extent only the Ombudsman upheld this part of Mr A's complaint.

The Ombudsman established from the records that Mrs A had been given regular morphine during her inpatient stay and therefore did not uphold this part of Mr A's complaint.

The Ombudsman concluded that there was no evidence to suggest that Mrs A had been suffering from pre-eclampsia. He also noted that the baby was healthy when delivered. He did not uphold this part of Mr A's complaint.

The Ombudsman's felt that in light of the failings identified around Mrs A's gastroenterological care the Health Board's complaint response could have been more robust. To that extent only he upheld this aspect of Mr A's complaint.

The Ombudsman made the following recommendations. The Health Board was asked to apologise to Mr

and Mrs A for the failings identified. In addition, the Health Board's inflammatory bowel disease ("IBD") team should continue to embed national guidance (the IBD Standards) into its clinical and working practices, and to facilitate wider learning, the Ombudsman's report should be discussed at a gastroenterology team meeting.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201801553– Report issued in November 2019](#)

Ms X complained about her father, Mr Y's, care between July and October 2017. She was concerned he was not placed on an appropriate ward for assessment of his dementia and was not transferred to another hospital for assessment. She was also concerned there was a failure to address the deterioration in Mr Y's mobility and his weight loss, assess him prior to his discharge to a care home and to address his persistent cough before discharge. Finally, she was concerned there was a failure to discuss the prescription of an antipsychotic medication with the family.

The Ombudsman found that the ward was appropriate for Mr Y's assessment and subsequent management. Whilst a decline in Mr Y's cognitive condition resulted in a referral to another hospital for assessment, when this did not transpire, Mr Y's dementia was appropriately assessed and managed on the ward. He did not uphold this complaint. He found that poor communication impacted on Mr Y's transfer for assessment which caused unnecessary distress to Mr Y's family. He upheld this complaint.

The Ombudsman found that, in the main, necessary steps were taken to address Mr Y's declining mobility and weight loss, with the exception that it would have been appropriate to involve a Dietician / SALT to address Mr Y's poor nutritional intake and weight loss. That said, cognitive decline and worsening dementia can lead to poor oral intake. The Ombudsman was unable to say whether these interventions would have altered the situation. He upheld this complaint because of this uncertainty.

The Ombudsman found discharge was appropriate and that while Mr Y might have benefitted from a SALT assessment before discharge, he was unable to say that Mr Y's cough was linked to a swallowing issue and the records / assessments did not document swallowing concerns or chest infection before discharge. He did not uphold these complaints.

Finally, the Ombudsman found that the administration of the antipsychotic was appropriate, but there was a failure to communicate the decision to Mr Y's family which caused distress and anxiety. He upheld this complaint.

The Health Board agreed to apologise for the failings and share the report with relevant staff for learning. It also agreed to carry out an audit of a sample of nursing documentation on the ward to review that appropriate referrals are made to a Dietician / SALT when poor nutritional intake and weight loss have been identified.

[Hywel Dda University Health Board - Clinical treatment in hospital](#) [Case Number: 201803707 – Report issued in November 2019](#)

Mr D complained about the care and treatment provided by Hywel Dda University Health Board to his mother (Mrs D) and the way it handled his complaint concerning an Emergency Department admission and discharge on 18 June 2017, and subsequent readmission and lengthy hospital stay. Mr D said Mrs D should not have been discharged, and that the Health Board did not communicate properly about Mrs D's condition or manage her pain, medication and wound appropriately.

The Ombudsman found the overall care and treatment provided by the Health Board to Mrs D on 18 June was reasonable, however it did not address this matter in its response to Mr D, therefore the concern about complaint handling was upheld. The Ombudsman found the overall care and treatment provided to Mrs D following her readmission was reasonable, however shortcomings concerning pressure sore prevention and wound management were identified, therefore these aspects of the complaint were partly

upheld. The Ombudsman found the Health Board had apologised to Mr D for some shortcomings regarding communication and this element of the complaint was not upheld.

The Health Board agreed to apologise to Mr D for the failings identified, to pay Mrs D £500 for the distress and inconvenience experienced, to share the report with relevant medical staff for critical reflection and to confirm an incident regarding barrier spray had been reported to the Medicines and Healthcare products Regulatory Agency.

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

[Case Number: 201805953 – Report issued in November 2019](#)

Ms A complained about the lack of timely care and treatment she received at the Prince Charles Hospital ("the Hospital"). She also complained about the lack of information given to her about her condition and its implications and the lack of urgency in providing her with follow-up appointments. Ms A also complained about complaint handling.

The Ombudsman's investigation concluded that the care and treatment provided to Ms A following her admission was timely and appropriate. However, given the fact that the Surgeon's record keeping was very scant, it was difficult to know what information was provided to Ms A about her diagnosis of pelvic inflammatory disease. The investigation found that whilst the Health Board's complaint handling was timely, it did not identify shortcomings in record keeping by the Surgeon. As a result, Ms A had to pursue her complaint further in order to get answers. Given that the failings identified caused Ms A an injustice, these aspects of her complaint were upheld.

The Ombudsman recommended that the Health Board apologise to Ms A for the shortcomings in record keeping. The Health Board was asked to remind the Surgeon of the importance of record keeping.

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

[Case Number: 201805038 – Report issued in November 2019](#)

Ms M complained about the care and treatment provided to her father, Mr A between 8 August and 18 October 2017 in Glangwili General Hospital and Withybush General Hospital. Her complaint included inadequate discharge planning, failure to have regard to Mr A's hearing impairment and ignoring his wishes not to discuss his terminal illness with him. Ms M also complained that the medical staff failed to prescribe her father medication in the Emergency Department ("ED"). Ms M also had concerns about what she saw as a failed and unsafe discharge as well as the failure to monitor her father's calcium levels as part of his end of life care.

Broadly the Ombudsman's investigation concluded that Mr A's care and management was reasonable, appropriate and within the bounds of acceptable clinical standards. The investigation however found service failings as there was a failure to prescribe Mr A's prescribed medication when he was in the ED. The Ombudsman also found that there was a missed opportunity to check Mr A's calcium level and prescribe him medication to alleviate some of his symptoms. These aspects of Ms M's complaint were upheld.

The Ombudsman recommended that the Health Board apologise to Ms M for the failings identified by the investigation. The Health Board was also asked to provide evidence of how it would address the issue of mislaid medication.

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

[Case Number: 201804992 – Report issued in November 2019](#)

Mr X and his brother complained that their father, Mr Y, did not receive appropriate care and treatment from the former Abertawe Bro Morgannwg University Health Board when he attended the Emergency Department ("ED") of Princess of Wales Hospital in November 2017. Mr X said that the lack of care directly contributed to Mr Y's death a few days later. Mr X also complained that, while Mr Y was in

the ED, communication with him about his father's clinical condition, was poor.

The Ombudsman found that whilst the initial actions taken when Mr Y was admitted to the ED were appropriate, there was a failure to act in a timely manner on signs that Mr Y's condition was deteriorating. In addition, a decision made by a doctor that Mr Y could be discharged was inappropriate in the circumstances (in the event, Mr Y collapsed as they were getting ready to leave and was then admitted to hospital). The Ombudsman upheld this part of the complaint to the extent that Mr Y did not receive appropriate care and treatment; however, he was unable to conclude that this directly contributed to Mr Y's death given his age and overall health. The Ombudsman also upheld the complaint about communication. It was not until over 10 hours after Mr Y arrived at the ED that there was a specific entry in the records that Mr Y's clinical condition and his treatment plan were discussed with his family.

The Ombudsman recommended that the Health Board apologise and pay redress of £1,250 to reflect the distress and uncertainty caused by the service failures identified by the investigation. He also made a recommendation relating to the recording in the notes of communication with patients and their families.

[Hywel Dda University Health Board - Clinical treatment in hospital](#)
Case Number: 201900771– Report issued in November 2019

Mrs R complained about the care and treatment provided by Hywel Dda University Health Board to her 6-year-old daughter, B, after she started to experience seizures in **2017**. She said there were delays in the assessment and diagnosis of B's epileptic seizures and that, when a diagnosis was achieved, it was incorrect because the Paediatrician was not appropriately qualified or experienced. She also complained that this led to a delay in B being prescribed appropriate medication.

The Ombudsman found that whilst the Paediatrician was appropriately qualified, he incorrectly diagnosed B as suffering absence seizures, when B was actually experiencing focal seizures. This was probably owing to inexperience in differentiating between the different types of epilepsy; the Ombudsman therefore partially upheld this complaint. The Ombudsman did not find any evidence of excessive delay in the investigation of B's seizures and he did not agree that B should have been prescribed medication during the period of care. He did not uphold these complaints.

The Ombudsman recommended that, within 1 month, the Health Board should apologise to Mrs R for the incorrect diagnosis and share the report with the Paediatrician so that he could consider its findings in his future practice. The Ombudsman also recommended that, within 3 months, the Health Board should review the training records of all Consultant General Paediatricians in its area. It should offer updated training on epilepsy to any individuals who had not already completed it and ensure that each district general hospital has provision to ensure that any children who have, or are suspected to have epilepsy can be reviewed by an appropriately qualified Paediatrician. The Health Board agreed to implement these recommendations.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#)
Case Number: 201807493 – Report issued in November 2019

Mr C complained that Cardiff and Vale University Health Board failed to examine his daughter's knee adequately following a fall. In particular, Mr C was unhappy at its failure to recognise that a piece of gravel was still embedded in her knee, which had to be removed by a hospital in England ten weeks later. The Ombudsman's investigation found that the initial examination Mr C's daughter underwent was inadequate and the junior doctor in the Emergency Department did not thoroughly examine or explore her wound. By not examining the wound, the piece of gravel remained in her knee for a further ten weeks, it subsequently became infected and Mr C's daughter had to be prescribed antibiotics by an out-of-hours GP two days later. The Ombudsman also found that the medical notes completed by the doctor were inadequate and too brief.

The Ombudsman concluded that this was a service failure and the discomfort suffered by Mr C's daughter

until the piece of gravel was removed was an injustice.

The Ombudsman recommended that within one month the Health Board should apologise to Mr C's daughter, pay her £500 in recognition of the substandard examination and the distress this caused and share the Ombudsman's report with the junior doctor in question so lessons could be learned.

The Health Board accepted the Ombudsman's recommendations.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201806469 – Report issued in November 2019

Mrs X complained about the treatment of her husband, Mr X, at Neath Port Talbot Hospital ("the Hospital") in 2017. She said that he had not been properly appraised of the risks of undergoing a procedure which had serious consequences for him. Mr X attended a day clinic to receive Botox injections - a recognised procedure for those suffering continence problems due to an overactive bladder. At the time, he was taking 2 blood thinning medications (known as dual anti-platelet therapy-DAPT) – aspirin and Ticagrelor. In January 2017 Mr X was sent home on arrival, apparently showing symptoms of infection. He returned in March and underwent the procedure, suffering a bleed during it. This was stopped, the procedure completed, and he went home. Later that day Mr X was admitted as an emergency suffering significant bleeding, and having developed life threatening urosepsis. He was an inpatient for months.

The Ombudsman's investigation found that there was no record of observations for Mr X to ascertain what symptoms he had presented with in January, that were seemingly absent in March (when urine test results were the same both times), to understand why it was deemed safe for Mr X to undergo the procedure the second time. He also found the use of the same admission form for both clinics to be "cutting corners", leading to an uncertainty that Mr X had been fully asked the questions from it on the second occasion. The Ombudsman found the consenting process in Mr X's case to be inadequate with no record of the discussion with him, no real evidence of an appreciation that Mr X was on DAPT, and consequently limited evidence of an evaluation of risk to him of undergoing the procedure without suspending DAPT. There was also no Health Board guideline in place about DAPT patients undergoing procedures. The Ombudsman upheld Mrs X's complaints about the failure in the consenting process and risk evaluation directly impacting upon Mr X, as it was an elective procedure. He did not uphold the complaint about allowing Mr X to go home after the bleed, as it was not inappropriate after a day procedure when the bleeding had stopped.

The Ombudsman made a number of recommendations including an apology and redress of £3000 to Mr & Mrs X. He recommended that those involved in undertaking surgical procedures be reminded of the importance of properly documenting consenting discussions. The Ombudsman also recommended that the Swansea Bay University Health Board should review its documentation and admission forms for day clinic procedures, as well as develop a written policy for dealing with the management of patients undergoing procedures whilst on DAPT. It agreed to do so.

Powys Teaching Health Board & Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201902970 & 201803603 – Report issued in November 2019

Mrs M complained that failings in the care and treatment that her daughter, Ms D, received from Aneurin Bevan University Health Board's Mental Health Services in late 2015 (services commissioned by Powys Teaching Health Board), contributed to her tragic suicide in January 2016. Mrs M complained about:

- a) Failings in the Consultant Psychiatrist's management of Ms D's medication in the weeks prior to her death.
- b) The failure of a Mental Health Social Worker to recognise and appropriately respond to Ms D's psychotic symptoms during and following an emergency consultation in November 2015.
- c) A series of failures of communication between Mental Health Services and the family.

The Ombudsman, through his Clinical Adviser, identified significant failings in Ms D's care and, consequently, upheld complaints a-c. However, he found no evidence to suggest that these failings caused or contributed to Ms D's tragic suicide.

The Ombudsman recommended that Aneurin Bevan UHB should provide Mrs M with a fulsome written apology for the clinical, procedural and communication failings the investigation identified and, in recognition of the inconvenience to which Mrs M was put as a result of poor communication, make a payment to her of £500.

The Ombudsman also recommended that the failings attributed to the Consultant and the Social Worker are discussed at their annual appraisals and that both Health Boards disseminate and discuss the report's key findings and learning points with senior, community-based mental health physicians/clinicians. Finally, the Ombudsman recommended that Aneurin Bevan UHB:

- Provides the Ombudsman with an account of how current procedures governing the responsibilities of Duty Desk officers address/preclude repetition of the failings identified in respect of the emergency consultation with the Mental Health Social Worker.
- Demonstrates to the Ombudsman that it has reminded senior mental health physicians and clinicians of the requirement to adhere to the provisions of established guidance governing record-keeping, suicide risk-assessment, psychotic relapse/crisis management and remote prescribing.
- Demonstrates that it has reminded senior mental health physicians and clinicians of the requirement to ensure that former service-users can access services quickly if they feel their mental health is deteriorating.

Both Health Boards agreed to implement these recommendations.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201805865 – Report issued in November 2019](#)

Mr A complained about failings in the care and treatment that his late wife, Mrs A, received at Morriston Hospital ("the Hospital") following her admission in August 2017 with kidney failure and leg ulcers caused by calciphylaxis (an accumulation of calcium in skin tissues associated with end-stage kidney failure). Mr A complained that failings of care caused or contributed to his wife's death from multiorgan failure on 29 September 2017. Mr A, assisted by his mother-in-law, Mrs B, complained that:

- a) Clinicians did not initiate haemodialysis (the filtering of blood with an external machine) during the admission in accordance with Mrs A's clinical need and with the family's requests.
- b) Clinicians failed to appropriately treat Mrs A's condition of calciphylaxis and failed to initiate other treatment interventions in response to her deteriorating condition.
- c) Whilst clinicians suggested that family members might consider the possibility of donating a kidney to Mrs A, she was never listed for kidney transplant.

The Ombudsman, through his Clinical Adviser found that, following a procedure to remove dead tissue from Mrs A's leg ulcers, there was a protracted delay in surgeons conducting a post-operative review. Whilst Mrs A's calciphylaxis was appropriately treated, this delay breached established clinical practice and caused Mrs A and her family considerable anxiety. The Ombudsman also found that there were insufficient clinicians available (out-of-hours) who were trained to operate Mrs A's peritoneal dialysis machine (a form of dialysis in which the lining of the abdomen is used as a natural filter). This necessitated a family member returning to the Hospital to perform this function. To this extent, the Ombudsman upheld complaint b).

However, the Ombudsman did not uphold complaints a) and c) and found no evidence to suggest that failings of care caused or contributed to Mrs A's death from multiorgan failure. The Ombudsman concluded that Mrs A had a complex and very dangerous combination of clinical problems that pre-dated

her admission to the Hospital. Although he was able to identify some deficiencies of care, he found no evidence that these altered the sad outcome of the admission.

The Ombudsman recommended that the Health Board provides Mr A with a fulsome written apology for the failings the investigation identified and that it should make a payment to him of £150 in recognition of the inconvenience and trouble to which he was put in journeying to and from the Hospital to manage Mrs A's dialysis machine. The Ombudsman also recommended that the Health Board provides details of measures it has introduced to prevent recurrence of the failure to conduct a post-operative review of Mrs A in a timely way and that it provides evidence that physicians have considered how the out-of-hours delivery of peritoneal dialysis might be achieved in future.

The Health Board agreed to implement these recommendations.

[Aneurin Bevan University Health Board & Caerphilly County Borough Council - Clinical treatment in hospital](#)

[Case Number: 201801956 & 201801955 – Report issued in November 2019](#)

Mr A complained to the Ombudsman about the way in which the Council and the Health Board handled his late mother (Mrs A)'s care. He had many concerns.

As against the Council, Mr A complained about the manner in which it managed Mrs A's admission to a Council owned and managed care home, and complained that it had failed to undertake appropriate capacity assessments or assessments under Deprivation of Liberty Safeguarding (DoLS) arrangements (procedures for those who lack capacity). Mr A was concerned that the professionals involved in his mother's care had not had adequate access to Mrs A's records to enable them to make the correct decisions and assessments.

As against the Health Board, he complained that it had failed to assess Mrs A's declining dementia appropriately and had failed to respond appropriately to a possible stroke identified by her GP. Mr A also considered that the Health Board failed to undertake appropriate assessments for NHS Funded Continuing Healthcare ("CHC funding") and about the way a POVA referral was handled following Mrs A's admission to hospital. Mr A claimed that wet sores on Mrs A's body and how they had been allowed to develop had not been investigated under the POVA process. He further questioned the arrangements for Mrs A's transfer to a different hospital shortly before her death. Mr A also complained about the manner the Council and the Health Board had dealt with his complaints about Mrs A's care.

The Ombudsman concluded that the Council's care home was an appropriate setting for Mrs A when she was placed there and did not uphold this complaint. He also determined that the decision not to convene a formal POVA meeting was appropriate in the overall circumstances of Mrs A's case and so did not uphold this element of Mrs A's complaint. Further, the Ombudsman found that Mrs A's care was not compromised at the Council's care home by the lack of full access to Mrs A's records as complained about. The Ombudsman concluded that the Health Board's investigation, diagnosis and management of Mrs A's dementia was appropriate. He did not uphold this element of the complaint or the complaint about the delay in assessing Mrs A's eligibility for CHC funding. He considered the delay appropriate in order to allow for Mrs A's condition to stabilise. The Ombudsman also found it was necessary to transfer Mrs A to a specialist setting for those dealing with dementia shortly before her death as she was medically fit for discharge and required dementia assessment.

The Ombudsman found that the assessments, services and treatments provided to Mrs A by the Council and the Health Board, following the diagnosis of a probable stroke by her GP, were inadequate. This element of the complaint against both public bodies was upheld. Similarly, the Ombudsman also upheld, as against both bodies, Mr A's complaint about the failure to assess Mrs A's mental capacity with sufficient promptness, or to assess her appropriately under DoLS processes. Finally, the Ombudsman found shortcomings in how both the Council and the Health Board had handled Mr A's complaints. He found

there had been inappropriate delays in responding to Mr A and so upheld this complaint.

The Ombudsman recommended that the Council and the Health Board apologise to Mr A for the failings identified. He also recommended that the Council amend its procedures (and training related to such) to ensure staff involved in arranging admissions to care homes were aware of the need to consider the capacity of the individual concerned to agree to the admission. Otherwise, staff should be aware of the need to ensure DoLS processes were followed for those persons lacking capacity.

In relation to the Health Board the Ombudsman recommended that it review its current approach to assessing suitability of care home placements to ensure that complex care needs are adequately assessed and that care plans are developed collaboratively with multi-disciplinary teams where required. He also recommended a review of its current practice in primary and community care services in relation to capacity assessment for those diagnosed with dementia.

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

[Case Number: 201803094 - Report issued in December 2019](#)

Ms Y complained about the care and treatment her partner Mr Z received in hospital. Ms Y complained that she was treated unfairly and that the Health Board did not consider Mr Z's Human Rights when it implemented safeguarding procedures and decided that Mr Z should not be resuscitated. Ms Y also complained about the way her complaint was handled.

Ms Y's complaint was mostly upheld. The investigation found that the Health Board failed to make an urgent cancer referral for Mr Z when a scan indicated one was necessary. The findings of the scan were not fully reported and as a result Mr Z and Ms Y were not advised of how ill Mr Z was and were unable to consider what options were available to them or have meaningful discussions about the situation. This was an injustice to Ms Y and Mr Z. However, once Mr Z was admitted to hospital it was reasonable not to undertake further invasive tests.

The investigation found that the Health Board had safeguarding concerns about Mr Z (owing to alleged actions of Ms Y including potential medication errors before Mr Z was admitted to hospital). The recording of these concerns was inconsistent and it did not discuss these issues with Ms Y or act on them until it became concerned about Ms Y's behaviour towards staff on the Ward.

The investigation found that the Health Board used the safeguarding process to restrict Ms Y's access to the Ward. The Health Board did not use its own "Handling violence and aggression" policy, which would have given Ms Y the opportunity to address the Health Board's concerns and a right of appeal against any restriction. The Health Board did not consider Mr Z and Ms Y's right to family life when imposing restricted supervised visits (one hour twice per week). Further the Health Board did not ensure that Mr Z had a voice in this decision as it had not acted swiftly on its concerns about whether Mr Z had capacity. Safeguarding documentation was brief and did not include a care plan and Mr Z did not have an advocate. The Health Board did not consult family members or a suitable advocate when making the decision not to resuscitate Mr Z. Although this was a reasonable clinical decision, Mr Z did have people in his life with whom the decision could have been discussed. This was an injustice to Mr Z and Ms Y.

The Health Board gave an assurance that if Mr Z's condition deteriorated Ms Y would be contacted, but in the event, it did not do this. Mr Z died on a day when Ms Y was restricted from visiting the Ward. The Health Board did not contact Ms Y until an hour after Mr Z's deterioration had become obvious. Ms Y was not able to be with Mr Z when he died. This was a significant injustice to both Mr Z and Ms Y.

The Health Board acknowledged that medication (which he had been receiving regularly for some time) had been issued to Mr Z on the Ward, in error, following a decision by a clinician that due to Mr Z's physical presentation, it was unlikely to be of any benefit. Mr Z's condition deteriorated after the medication was given to Mr Z and he died shortly after. The investigation found that there was no clinical

evidence to suggest that this medication error caused the sudden deterioration in Mr Z's condition.

The investigation found that the Health Board had reported its safeguarding concerns about Ms Y (including a potential medication error which had been resolved and was not believed to be linked to Mr Z's deterioration) to both Mr Z's brother and the Coroner, yet it failed to inform either of the medication error (immediately before Mr Z died) by its member of staff. This matter caused Ms Y significant distress.

Ms Y's complaint about the way her complaint was handled was partly upheld. Given the complexity of the complaint it was addressed in a reasonable timeframe. The Health Board's report covered all of the issues Ms Y raised including some from an admission the previous year. However, there were some inaccuracies in the report which caused Ms Y some distress. The Ombudsman found that there had been a difficult relationship between Ms Y and the Health Board. The Health Board exercised good practice by providing Ms Y with a senior single point of contact who was diligent in responding to extensive and challenging correspondence. The Health Board also offered to meet Ms Y on two occasions to discuss its report, but Ms Y did not attend those meetings.

The Health Board agreed to apologise for the failings identified in the report and make a payment to Ms Y of £2750. It also agreed to review the information relating to its medication error (on the day Mr Z died) and consider whether further action needed to be taken.

The Health Board agreed that the staff involved in the case should reflect on the findings with their supervisor and discuss the findings in respect of the reporting on the scan at a Radiology Discrepancy Learning Meeting.

The Health Board agreed to review documentation for the assessment and monitoring of confusion. It also agreed to review the "Handling violence and aggression" policy with specific reference to balancing the Human Rights issues and review the current knowledge of staff who may be involved balancing Human Rights matters when making decisions.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201806506 - Report issued in December 2019](#)

Mr X complained about the care and treatment that his late mother, Mrs Y, received from Abertawe Bro Morgannwg University Health Board (now Swansea Bay University Health Board) during her admissions to Morriston Hospital in late 2016 and early 2017. In particular, he complained about the Health Board's management of Mrs Y's diabetes and that she had been kept nil-by-mouth ("NBM") while waiting for surgery. He also raised concerns about the decision to give his mother patient-controlled analgesia ("PCA") as well as the failure to prescribe or provide pain medication in capsule form despite her being unable to swallow tablets. Finally, Mr X complained that the Health Board failed to address the above issues in accordance with the early resolution settlement that was agreed with the Ombudsman in November 2018.

The Ombudsman found that, whilst some aspects of Mrs Y's diabetes management during each of her admissions were reasonable, there were several failings in relation to the monitoring of her diet and the administration and management of her insulin by nursing staff. These failings would have had an impact on Mrs Y's blood sugar levels and might have also contributed to her experiencing hypo- or hyperglycaemic events at times. Therefore, the Ombudsman upheld this aspect of the complaint. Furthermore, although he concluded that the initial decision to prescribe a PCA was not inappropriate, and that the evidence overall did not suggest that Mrs Y had experienced an opioid overdose, the Ombudsman found that there were subsequent failings in the monitoring and recording of the PCA use. In addition, he found that provision of paracetamol in capsule form was not always consistent during Mrs Y's admissions, despite it being recognised in the records that she preferred these and had been specifically prescribed capsules. As a result, the Ombudsman upheld both complaints to those limited extents.

Finally, the Ombudsman determined that the Health Board had failed to comply with the agreed early resolution and the timescale by which this was to be carried out, which led to a delay in Mr X's concerns being investigated by the Ombudsman. The Ombudsman did not, however, uphold Mr X's remaining complaint about his mother being kept NBM while waiting for surgery. This was because it was correct for nursing staff to have followed an NBM protocol each day in preparation for surgery and that, although unpleasant, it was unlikely that Mrs Y would have come to any harm during this period.

The Ombudsman recommended that the Health Board apologise to Mr X and offer a payment of £625 to reflect the failings that he identified. He also recommended that the Health Board reminds nursing staff of the importance of maintaining accurate and complete food charts and that the report is shared with the relevant staff involved in complaint handling for them to reflect on its findings. Furthermore, the Ombudsman made a series of recommendations around the training of staff in relation to diabetes management, that the Health Board carries out a review of the monitoring of PCAs on the relevant ward and that it considers how staff can manage the potential situation where individuals other than the patient might press the PCA. The Health Board agreed to implement the recommendations.

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

[Case Number: 201806446 - Report issued in December 2019](#)

Ms A complained about the ineffective management of her late father Mr B's kidney disease. She was concerned that his kidney medication was the underlying cause of the pleural effusion (a build-up of excess fluid in between the membranes surrounding the lung) that developed in his right lung and that this in turn had led to his death from bronchopneumonia. Ms A was also dissatisfied with the robustness of the Health Board's complaint handling and its complaint response.

The Ombudsman's investigation concluded that Mr B's pleural effusion was not a direct cause of his bronchopneumonia and did not uphold this part of Ms A's complaint.

The Ombudsman did identify shortcomings around the complaint handling process including the quality assurance process which had contributed to a complaint response that was factually inaccurate in places. The Ombudsman therefore upheld this aspect of Ms A's complaint.

The Ombudsman's recommendations included the following. The Health Board was asked to apologise to Ms A for the failings identified around complaint handling and to provide her with additional information relevant to the complaint. It was also asked to review its complaint handling in Ms A's case to see whether other lessons could be learnt.

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

[Case Number: 201805835 - Report issued in December 2019](#)

Ms D complained about the care and treatment she received from Hywel Dda University Health Board in September 2017 when she suffered a miscarriage. Ms D was particularly unhappy that she underwent an internal examination that she said caused her to bleed afterwards and lose her baby. Ms D was also unhappy at the way staff treated her when she was discharged from Glangwili Hospital, especially with regard to arranging her own transport home. Ms D also complained about having to wait in an ambulance for a number of hours prior to being admitted for a second time and then being left on her own in the hospital to deliver her baby.

The Ombudsman found that the internal examination was highly unlikely to have caused Ms D to bleed or to have resulted in her miscarriage. He also concluded that, although Ms D waited in an ambulance for an excessive amount of time, it had no significant impact on her overall health and condition. There was also no evidence that Ms D was left on her own to deliver her baby. The Ombudsman did not uphold these elements of the complaint.

However, the Ombudsman did uphold Ms D's complaint about the way staff treated her during her first admission. He found that, contrary to national guidance, an ultrasound was not performed which would have determined sooner whether there was a foetal heartbeat. The Ombudsman also found that there was no evidence of welfare checks being carried out while Ms D waited to go home following discharge and that she should have been admitted when she experienced difficulty organising transport. The Ombudsman could not be certain how much language was a barrier (Ms D's second language was English) in Ms D's care, but was satisfied it played some part.

The Ombudsman recommended that the Health Board apologise to Ms D for the failings identified. He also recommended that the report was shared with staff involved with Ms D's care so lessons could be learnt regarding the completion of accurate medical records and to ensure relevant national guidelines were adhered to at all times. The Ombudsman also recommended that the report was considered alongside the Health Board's policy on treating patients whose first language is not English to identify what, if any, improvements could be made.

[Betsi Cadwaladr University Health Board - Clinical treatment outside hospital](#) [Case Number: 201806893 - Report issued in December 2019](#)

Mrs X complained that her adult daughter, Ms Y, had not been provided with appropriate care and treatment by the Health Board. Specifically, Mrs X complained that the risks that Ms Y posed to herself in 2017 were not properly assessed and she did not receive appropriate care or treatment; that Ms Y's physical health was not investigated appropriately or in a reasonable timescale following her attendance at the Emergency Department in March 2017; and that Ms Y did not receive appropriate alcohol or drugs tests on admission to hospital. Mrs X also complained that the Health Board did not handle her complaint properly.

The investigation found that broadly, the mental health care Ms Y received from the Health Board was reasonable. However, it found that the Health Board did not properly assess the risks Ms Y posed to herself in March 2017, and did not properly co-ordinate Ms Y's care from June 2017. These service failures caused injustice to Ms Y, who may have received more suitable care or treatment earlier had they not occurred. Due to Ms Y's conditions however, the investigation could not determine whether more timely or appropriate treatment would have prevented her death.

The investigation found that the failure to refer Ms Y to the Gastrointestinal Clinic when she complained of vomiting blood, was a service failure which caused her an injustice as she continued to experience pain. The investigation did not uphold the complaint that Ms Y did not receive appropriate alcohol or drugs tests on admission to hospital as test results were identified.

The investigation also upheld Mrs X's complaint that her complaint had been handled inappropriately by the Health Board, which had caused her distress at a very difficult time.

The investigation recommended that the Health Board should, within 1 month, apologise to Mrs X and her family and should specifically acknowledge the aspects of care which were not of a good enough standard. It also recommended that the Health Board should pay £250 to Mrs X for the issues with complaints handling which were identified. The investigation recommended that the members of staff who assessed Ms Y in March 2017 should receive training on assessment of risk within 3 months, and that the Concerns Team should re-draft standard letters to advise people of their right to advocacy support in cases where a concern has been raised as a result of the Health Board's own processes (as well as where the person has brought a complaint).

Finally, the investigation recommended that, within 6 months, the Health Board should review its Upper Gastro Intestinal Bleeding Pathway policy to specifically explain when an outpatient endoscopy should be considered.

Not Upheld

Welsh Ambulance Services NHS Trust - Ambulance Services Case Number: 201803485 – Report issued in October 2019

Miss X complained about the delay in the Welsh Ambulance Services NHS Trust (“WAST”) attending her mother’s (Mrs Y) home address after she had fallen on 12 February 2018.

The Ombudsman concluded that all of the 999 calls that were made by Mrs Y’s husband on 12 February were correctly categorised with the appropriate prioritisation (Amber 2) applied. The later escalation to an Amber 1 prioritisation was also appropriate based on the information about Mrs Y’s worsening condition that had been provided by staff who were already at the scene. The availability of ambulances, and so WAST’s ability to respond to such calls on that day, had been reduced by an increase in the number of emergency calls that it had received and significant delays in ambulances transferring the care of patients to hospital staff. The Ombudsman considered WAST to have made every effort to attend Mrs Y’s home as soon as reasonably practicable. He also noted that other types of vehicles, although not necessarily suitable resources for the categorisation of the calls, were nevertheless dispatched in order to provide support to Mrs Y while she waited for an ambulance. As a result, the Ombudsman did not uphold the complaint.

Llansamlet Surgery - Clinical treatment outside hospital Case Number: 201806899 – Report issued in October 2019

Mrs X complained about the treatment provided to her son, Y, by the GP Practice between March 2015 and September 2017, and whether there were missed opportunities to have diagnosed Y’s tumours sooner.

The Ombudsman found that there was no evidence to suggest that the GPs who saw Y failed to undertake appropriate examinations or make appropriate referrals. The care provided to Y did not fall below an acceptable standard. He did not uphold the complaint.

Radyr Medical Centre- Clinical treatment outside hospital Case Number: 201900735 – Report issued in October 2019

Mrs G complained that a doctor at a GP Practice within the area of Cardiff and Vale University Health Board failed to assess and treat her daughter (“Ms A”) appropriately when she attended a routine appointment on 7 June **2018**.

The GP diagnosed Ms A with tonsillitis and prescribed a course of antibiotics, noting that Ms A should come back to the Practice if her symptoms worsened. In the early hours of the following morning Ms A died. The Coroner found that microscopic analysis showed that Ms A’s tonsils were inflamed, which was consistent with the GP’s diagnosis. However, there were also features of pneumonia evident in Ms A’s lungs, which was the most likely cause of her death.

The Ombudsman found that there was no way that the GP could have known when he examined Ms A what microscopic analysis of her lung tissue would, ultimately, reveal. The clinical examination of Ms A was in accordance with clinical guidance and there was no indication of pneumonia from the symptoms Ms A reported or the clinical examination findings, or any “red flags” which should have prompted the GP to do anything more. The Ombudsman did not uphold the complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital Case Number: 201900525 – Report issued in October 2019

Mrs S complained that the Health Board failed to appropriately monitor and manage the reduction of her epilepsy medication, Clobazam, and that it did not take appropriate action when she began to experience withdrawal side effects. Mrs S said that this resulted in her being detained under Section 2 of the Mental Health Act.

The Ombudsman found that the dose of Clobazam Mrs S was prescribed was modest, and that her Neurologist's plan to withdraw it, by first reducing the dose and then stopping it altogether, was in line with standard best practice. Mrs S had adequate and appropriate access to the specialist epilepsy nursing service and the care she received from it appeared to have been of a high standard. Furthermore, there was nothing from the records to indicate that the Clobazam reduction was inappropriate or that withdrawal symptoms caused the deterioration in Mrs S's mental health. The Ombudsman did not uphold the complaint.

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

[Case Number: 201804649 – Report issued in October 2019](#)

Mrs X complained that the Health Board's Podiatry Team failed to diagnose and appropriately treat the problems her daughter, A, was experiencing with her left foot.

The investigation found that the Podiatry Team made a reasonable diagnosis based on the information available and that an appropriate treatment pathway had been put in place. The complaint was not upheld.

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

[Case Number: 201804345 – Report issued in October 2019](#)

Mrs A complained about the appropriateness of the Health Board's recommendation for her to undergo a natural birth for her second child, despite continual pain and treatment before and during her pregnancy (resulting from the birth of her first child two years earlier).

The Ombudsman found that there was no medical or obstetric reason why Mrs A should have been advised against a natural birth for her second child. Mrs A's medical records showed that the options for delivery of her second child were discussed with her and she was made aware that following a natural birth, there was a risk that her symptoms may worsen. The complaint was not upheld.

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

[Case Number: 201805292 – Report issued in November 2019](#)

Mrs X complained that there was a failure, on the part of staff at Ysbyty Glan Clwyd, to provide her husband, Mr X, with appropriate medication for symptom relief (including pain, breathlessness and agitation) and that his steroid medication was abruptly withdrawn, which accelerated his deterioration and sad death. Mr X was suffering from advanced lung cancer and pneumonia.

The investigation concluded that it was unsatisfactory that no Medication Administration Record (MAR) for the admission in question was completed and retained by staff on the ward. That amounted to maladministration. However, the investigation found, based on the other information available in the clinical records and on balance, that the medications to relieve Mr X's symptoms were managed appropriately, despite the lack of a MAR.

The investigation found that it was unlikely that the absence of a steroid dose on one day of the period in question accelerated Mr X's death. The complaint was **not upheld**.

It was, however, suggested that the Health Board should undertake an audit to ensure that Medication Administration Records were being properly completed and retained on the relevant ward.

[Mountain View Health Centre - Clinical treatment outside hospital](#)

[Case Number: 201802878 – Report issued in November 2019](#)

Ms X complained that a GP at the GP Practice unreasonably delayed referral to a specialist and a diagnosis of her breast cancer. Ms X said that she visited the GP Practice in the months leading up to March 2018 regarding a very painful breast lump in her left breast. She said that on each occasion she was sent away after being reassured it was a blocked milk duct, which would take three months to disperse, and advised

to take primrose oil (a treatment for blocked milk ducts). Ms X said that she explained at each visit that she had previously had a non-cancerous breast lump removed from her right breast when she was in her late teens, as she felt there was more to this recent lump. Ms X said that when she saw another GP (at an appointment in March 2018) they identified a breast lump and made an urgent suspected cancer referral. Soon afterwards, Ms X was found to have breast cancer.

Due to the irreconcilable and conflicting evidence, the investigation could not make a robust finding in respect of whether the care provided at the appointment in December 2017 had been appropriate. Similarly, the investigation could not determine whether the presence of a breast lump at the appointment in January 2018 had been missed by the GP. However, the absence of any details regarding the advice given to Ms X to return to the Practice, if there were concerning developments associated with her painful left breast, amounted to service failure. This service failure was likely to have led to a delay of up to 5 weeks in Ms X being referred for an appointment at the local Breast Clinic. However, this delay was unlikely to have had a detrimental effect on Ms X's prognosis, the progression of her condition or the treatment of her cancer. Therefore, the complaint was **not upheld**.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201804375 – Report issued in November 2019

Ms A's advocate, Ms B, submitted a complaint on her behalf that:

- a) Ms A was given Electro-Convulsive Therapy ("ECT" - a form of medical treatment in which a small, carefully controlled electrical current is introduced in the brain) treatment against her will while under section 3 of the Mental Health Act 1983 ("the Act") despite her wishes being communicated verbally and by letter to relevant clinicians
- b) Ms A's clinical records did not evidence the required capacity assessments either before ECT treatment was commenced or at each administration of the treatment.

The Ombudsman found the clinical team were aware Ms A did not wish to have ECT treatment. However, she did not have an applicable advanced decision and the decision to treat Ms A with ECT was appropriate and carried out in line with the requirements of the Act and associated Code of Practice. He did not uphold this complaint.

The Ombudsman also found that Ms A's capacity was assessed before ECT treatment commenced and it was determined she did not have capacity to consent to treatment. A second opinion was sought which was in line with legislative requirements. Ms A's capacity was also assessed during ECT and it was determined she continued to lack capacity to consent to ECT. In addition, there was a valid certificate authorising a course of ECT and Ms A's clinical status was assessed following each ECT session. The Ombudsman did not uphold this complaint.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201804894 – Report issued in November 2019

Mrs B complained about the mental health treatment and care provided for her adult son, Mr C, between August and December 2017. Particularly, Mrs B said that the Health Board:

- Failed to admit Mr C to the Mental Health Unit ("the MHU") following an assessment at home in August.
- Reduced Mr C's medications too quickly causing worsening behavioural problems following his admission in October.
- Discharged Mr C prematurely from the MHU in December, placing both himself and others at risk of harm due to his volatile behaviour.
- Failed to involve Mr C's family in the discharge decision.
- Discharged Mr C without appropriate medication and arrangements for ongoing support.

The investigation found that the decision making around Mr C's admission and discharge was in line with

expected practice, and that the risks were appropriately assessed. Mr C's medications were also reviewed and managed appropriately. Mr C was admitted to the MHU as a voluntary patient. As he did not meet the conditions for involuntary detention under the provisions of the Mental Health Act, treatment could only be given with his co-operation. Mr C took the decision to discharge himself from the MHU in December, against medical advice, and left immediately. Consequently, the Health Board did not have the opportunity to plan for his discharge or to put any further support arrangements in place. Mrs B's complaints were not upheld.

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

[Case Number: 201805360 – Report issued in November 2019](#)

Mr X complained that there had been a failure to diagnose the fracture of his right shin bone when he attended his local Minor Injuries Unit on two occasions in November 2017.

The investigation found that Mr X had been appropriately examined, and, whilst there was evidence of a fracture on an MRI scan undertaken in January 2018, there had been no indication of such an injury on the original X-rays. The investigation also found that the investigations and treatment pathway undertaken had been in accordance with the relevant National Institute for Health and Care Excellence guidelines. The complaint was not upheld.

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

[Case Number: 201806701 - Report issued in December 2019](#)

Mr X complained that the Health Board failed to provide his wife Mrs X, with appropriate care and treatment between May 2018 and her sad death in September of the same year. He complained that it had been inappropriate for the Health Board to move Mrs X from the Royal Gwent Hospital ("the First Hospital") to Ysbyty Ystrad Fawr ("the Second Hospital") as she had been receiving specialist liver treatment. Mr X was aggrieved that the care and treatment Mrs X received at the Second Hospital was inadequate. Mr X was concerned that the medical equipment provided by clinicians at the Second Hospital to assist with her back pain was inappropriate. Mr X complained that when Mrs X became increasingly unwell in August 2018, the Health Board delayed her return to the First Hospital for further treatment.

The investigation found that it had not been inappropriate to move Mrs X to the Second Hospital given the need to address her back pain (with physiotherapy input) and that the only treatment available for Mrs X's cholangitis (infection in the bile ducts which drain the liver) was antibiotics, which were managed appropriately. The Second Hospital's inability to change the stent to drain Mrs X's common bile duct was unlikely to have caused Mrs X any detriment. The broad care and treatment provided to Mrs X by the Gastroenterology Team (with input from the liver specialists), Spinal Surgeon and Physiotherapy Team at the Second Hospital were found to be appropriate. The spinal brace used to manage Mrs X's back pain was appropriate, although there were difficulties in obtaining a comfortable fit of the brace. The investigation found that although there was a significant delay in transferring Mrs X back to the First Hospital after a decision had been made that she should be transferred, this was because of capacity issues. Reasonable efforts were made by staff to facilitate the transfer and she was transferred as soon as a suitable bed became available. Mr X's complaints were, therefore, **not upheld**.

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

[Case Number: 201806188 - Report issued in December 2019](#)

Mrs G complained about the care and treatment provided by Betsi Cadwaladr University Health Board and its Community Dental Service ("the Dental Service") to her adult daughter, K (who has learning difficulties), and its communications concerning 2 tooth extractions and retained roots.

K had all her teeth removed by the Dental Service between 1993 and 2016 for health reasons. However, in 2018 she began to complain of severe toothache. Mrs G said that when she contacted her usual Dental Service she was unable to access it, owing to unforeseen closure. Mrs G was advised to take K to an

alternative Dental Service facility which, Mrs G said, was too far away and not an option for her, so she had no option but to pay for private treatment instead. Mrs G said the private dentist diagnosed and removed two retained roots. Mrs G said she did not know about the roots and the Dental Service should have told her about them and that, without treatment, K could have remained in pain.

The Ombudsman found that Mrs G and K were informed in 2011 about the retained roots which caused symptoms in 2018, and that the previous Dental Service care and treatment, including the decision to leave the roots in place, had been reasonable. It was noted that the Health Board had apologised for the pain and the distress experienced, and the unforeseen closure and had taken steps to address Dental Service availability and improve the service it offered. The Ombudsman considered the Health Board's response to be reasonable and the complaint was not upheld.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201902206 - Report issued in December 2019](#)

Mrs X complained that there was a delay by Betsi Cadwaladr University Health Board ("the Health Board") in diagnosing her with breast cancer.

The investigation found that the Health Board missed 2 opportunities to conduct a biopsy of Mrs X's right breast and that the failure to biopsy Mrs X's right breast at the earliest opportunity led to a delay in diagnosing her with breast cancer.

In considering the injustice caused to Mrs X, the investigation found that, had the breast cancer been identified at the earliest opportunity, the treatment offered to Mrs X would have been the same. Mrs X would have required a mastectomy regardless of when the cancer was diagnosed as she was not eligible for radiotherapy treatment. The investigation therefore concluded that the failings identified did not cause an injustice to Mrs X. In the absence of evidence of an injustice to Mrs X, the complaint was not upheld.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201902339 - Report issued in December 2019](#)

Mrs X complained about the care and treatment provided to her young daughter, Y, at the University Hospital of Wales ("the Hospital"). Mrs X was unhappy that Y had been discharged from the Hospital on 2 occasions in a 24-hour period, but had later been hospitalised in France.

The Ombudsman found that the clinical assessments of Y had been appropriate, and that both discharges from the Hospital had been clinically reasonable, as it appeared that Y had a viral infection. The Ombudsman found that the Hospital had provided Mrs X with advice on returning to the Hospital should Y's condition become worse. The Ombudsman also found that the Hospital had prescribed appropriate antibiotics to Y as a precaution. The complaint was therefore **not upheld**.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201807430 - Report issued in December 2019](#)

Mrs A complained about an extravasation injury (where a cannula often becomes displaced ("tissued") leading to the delivery of fluids or drugs into the surrounding tissues) she sustained during an emergency caesarean section at Singleton Hospital's Maternity Unit. Mrs A said that she was not given adequate information about the situation immediately, nor was the risk of an extravasation injury discussed with her as part of the consenting process.

The Ombudsman's investigation did not find any evidence to suggest that the care provided to Mrs A was other than reasonable and appropriate. The Ombudsman was satisfied that there was appropriate communication and discussion with Mrs A concerning the extravasation injury, and verbal consent, although unnecessary, was obtained prior to the washout procedure. The Ombudsman was also satisfied that as the failure to cannulate and the subsequent dislodging/leaking of the cannula is a relatively common occurrence it is not normal practice to document the risk and therefore Mrs A's complaint was not upheld.

Early Resolution or Voluntary Settlement

Hywel Dda University Health Board - Patient list issues

Case Number: 201902291 – Report issued in October 2019

Mr M complained that the Health Board had failed to provide him with an appropriate Specialist service for Attention Deficit Hyperactivity Disorder (“ADHD”) and that he was unable to obtain prescriptions for ADHD medication for around seven years. The Health Board has an established practice of agreeing a Shared Care Protocol with GPs, under which the GP agrees to issue ongoing repeat prescriptions for medication while a specialist takes overall responsibility and agrees to review the patient if necessary. However, there was a substantial waiting list to see the Specialist because of limited capacity, and priority was given to patients who were being treated under the Shared Care Protocol, or who were already on medication. The Health Board said that it had allocated resources to recruit more Specialist staff and in the meantime, the shortfall in service for adults with ADHD had been placed on the Mental Health and Learning Difficulties risk register. In addition, these issues would be escalated to the Health Board's executive team to consider how it could ensure adequate and sustainable service provision. Following contact from the Ombudsman, the Health Board also offered Mr M an appointment with the Specialist and began contacting GPs locally to ask whether they would agree to the Protocol.

The Ombudsman found that there was some confusion over whether Mr M's current GP was willing to agree to the Protocol and whilst the Health Board said it had been in correspondence with Mr M's GP, it was unable to locate the relevant correspondence. Furthermore, whilst an appointment had been offered, there was uncertainty around how Mr M would be able to obtain his prescriptions in the event that the Specialist recommended medication.

The Health Board agreed to undertake the following actions in settlement of the complaint and before the date of Mr M's forthcoming appointment with the Specialist:

- a) Apologise to Mr M for the length of time it had taken to secure an appointment with the Specialist and offer him £250 for his time and trouble in pursuing his complaint.
- b) Investigate the circumstances surrounding the missing correspondence and clarify to Mr M what contact had been made with his current GP (and copy that explanation to the Ombudsman).
- c) Contact Mr M's current GP and confirm, definitively, whether he will agree to the Protocol if the Specialist concludes that it is appropriate to prescribe medication to Mr M. In the event that the GP does not respond or does not agree, the Health Board should continue to identify which GPs will agree to the Protocol and share that information with Mr M so that he can transfer to an alternative GP if necessary.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201903448 – Report issued in October 2019

Ms A complained about the length of time the Health Board was taking to respond to her concerns about the care and treatment provided to her son over a number of years which included a misdiagnosis. The Ombudsman contacted the Health Board as it was concerned about the length of time so far taken and was told that it is a very complex matter, covering matters over a five year period and also involved many different specialities. However, most of the delay was due to having to contact the redress team to consider whether there was a potential breach of duty.

The Health Board agreed to undertake the following actions no later than 25 October 2019: -

- a) Apologise to Ms A for the length of time taken to conclude its investigation.
- b) Offer £250 for the delay and distress caused.

c) Issue its response letter.

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

[Case Number: 201904265 – Report issued in October 2019](#)

Mrs X complained that 6 months have passed since she submitted her complaint to Betsi Cadwaladr University Health Board (“the Health Board”). Mrs X complained that she is still awaiting its response and she further complained that she has not been kept updated on its investigations in line with Putting Things Right (“PTR”) guidelines.

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

1. Issue its PTR response to Mrs X by 21 November 2019, ensuring that the response includes a clear explanation as to why it has failed to update Mrs X and taken 6 months to provide its formal response.

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

[Cwmbran Village Surgery - Clinical treatment outside hospital](#)

[Case Number: 201904069 – Report issued in October 2019](#)

Mrs X complained that a referral letter from her GP at Cwmbran Village Surgery (“the Surgery”), for a sinus issue, contained sensitive medical information regarding a past termination of pregnancy. Mrs X took the referral letter home, ready to pass to her consultant, and left it on her kitchen table where her son read it. Mrs X said that this has caused a rift between her and her son.

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

By 25 October 2019:

1. To issue a furthermore meaningful apology to Mrs X, apologising for the error in including the information about the termination and the upset it indirectly caused.

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

[Swansea Bay University Health Board - Continuing care](#)

[Case Number: 201903609 – Report issued in October 2019](#)

Mr X complained that he had been invoiced for Continuing Health Care (“CHC”) fees covering the period October 2018 to April 2019. He did not believe he owed this money and had contacted the Health Board to try to clarify certain aspects of the decision making process. He had been unable to obtain a clear explanation.

Although the Health Board were unable to review this complaint under the framework for considering retrospective CHC claims, in settlement of this complaint it has agreed to consider it under its formal complaints process. The Health Board agreed to provide Mr X with a formal response within the next **30 working days** which will address possible shortcomings of the original CHC assessment and the subsequent handling of the correspondence.

[Gateway Dental Practice - Clinical treatment outside hospital](#)

[Case Number: 201903532 – Report issued in October 2019](#)

Mr F complained that he was incorrectly advised by the Dental Practice that he was entitled to free dental treatment. Mr F said he completed a claim form and received free treatment but later incurred a penalty charge because he was not, in fact, entitled to it. The Dental Practice accepted that it had provided incorrect advice to Mr F and agreed to carry out the following actions:

- a) Provide a written apology to Mr F for the incorrect advice provided in relation to the claim form within 10 working days.
- b) Provide additional evidence to the NHS Business Services Authority (NHSBSA) to support Mr H's challenge against the penalty notice as and when requested by the NHSBSA.
- c) Ensure that the following NHSBSA educational information is made available in patient waiting areas within one month if it is not already:
 - Dental patient fact sheet (2018)
 - Dental patient fact sheet (easy read)
 - Penalty notice warning poster
- d) Ensure that staff are familiar with the NHSBSA's guidance for dental staff.
- e) In the event that Mr F's challenge against the penalty charge is unsuccessful, to consider what further actions the Practice might take in the interests of maintaining goodwill with him.

The Ombudsman considered that the agreed actions represented a reasonable resolution to Mr F's complaint.

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

[Case Number: 201903227 – Report issued in October 2019](#)

Ms X complained on behalf of Mr Y that the Health Board inappropriately placed him on stage 1 of its violence and aggression policy ("the Policy"). She also complained about the Health Board's decision to withdraw 1 to 1 sessions with a community psychiatric nurse ("CPN").

The assessment found that the decision to place Mr Y on stage 1 of the Policy was a decision it was entitled to take and had been appropriately reached. The Policy did not, however, contain a review mechanism. The Health Board agreed to amend the Policy to include a review mechanism so that decisions could be made about the appropriateness of patients remaining on the Policy after a set time period and information provided to patients accordingly.

The assessment found no evidence to suggest that the decision to withdraw one to one sessions with a CPN was unreasonable. The Health Board had taken into account relevant considerations in reaching its decision and had offered Mr Y reasonable alternatives to continue his service provision.

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

[Case Number: 201902664 – Report issued in October 2019](#)

Mrs A complained that the Health Board had failed to provide her with an appropriate bed to assist her with her health condition. She also complained that the Board's communication had been poor both with regards to her ongoing care and its complaints procedure.

The Ombudsman was concerned that there appeared to be a lack of co-ordination between departments involved in Mrs A's care. He was also concerned by the apparent lack of communication with Mrs A as part of her ongoing care. It appeared that the lack of communication and delay in ordering the new bed resulted from an unexpected long term absence of one of the Health Board's staff members. The Health Board advised that it had written to Mrs A following an assessment of her health condition and confirmed that a new bed had been ordered.

The Ombudsman contacted the Health Board and it agreed to:

- a) Provide the Ombudsman with evidence that it had written to Mrs A.
- b) Arrange a professionals' meeting of the specialities involved in her care to be followed up by a multi-disciplinary meeting at her home.

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

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

[Case Number: 201904060 – Report issued in October 2019](#)

Mr A complained about the delay in receiving a response from Aneurin Bevan University Health Board ("the Health Board") following his dissatisfaction with its initial response to a complaint he had made. The Ombudsman found there was evidence of poor communication during the complaints handling process.

The Health Board agreed to take the following action to resolve the complaint:

- a) To apologise to Mr A for the delay in providing a response
- b) To provide a full response to Mr A within four weeks

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

[Case Number: 201902753 – Report issued in October 2019](#)

Mr A complained to the Ombudsman about the delay and lack of communication he received from Cwm Taf Morgannwg University Health Board ("the Health Board"). Mr A had complained to the Health Board under Putting Things Right regulations ("PTR") about the standard of care and treatment provided to him, however, the Health Board did not provide a response to his concerns.

The Ombudsman found that there was evidence of poor communication when the Health Board did not respond to Mr A under the parameters of the PTR regulations.

The Health Board agreed to take the following actions in response to Mr A's complaint:

- a) To provide a full PTR response to Mr A within six weeks
- b) To apologise to Mr A for its poor communication and lack of the required updates
- c) In addition the Health Board will expedite a follow up appointment for Mr A

[Meddygfa Victoria Surgery - Medical records/standards of record-keeping](#)

[Case Number: 201903678 – Report issued in October 2019](#)

Miss X complained about the Surgery's failure to provide her with a summary of the discussion from a complaint meeting held earlier this year.

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

- a) Ensure that a summary of the discussion is sent to the Compliance Team for the Local Health Board within three weeks.

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

[Case Number: 201804421– Report issued in October 2019](#)

Mr A complained about the care and treatment provided to him by the Health Board for suspected prostate cancer. Mr A said a multiparametric magnetic resonance imaging (mp-MRI) scan was not made available to him in accordance with NICE guidance. Mr A said that as a result, he had to pay for a private mp-MRI scan. Mr A also complained about the way the Health Board dealt with his complaint about the matter.

The Ombudsman found the Health Board had undertaken a review of Mr A's case during the investigation and agreed to refund the cost of the private scan. The Health Board confirmed it offered post biopsy mp-MRI scans in accordance with NICE guidance and had developed implementation plans for a North Wales

mp-MRI service with provision of mp-MRI across 3 major hospitals in the area. The Health Board also accepted that there were failures in its handling of Mr A's complaint and agreed to apologise to Mr A for that and pay him £250 in recognition of the time and trouble he had been put to. The investigation was discontinued as the Health Board's actions resolved Mr A's complaint.

Cardiff and Vale University Health Board - Clinical treatment outside hospital Case Number: 201904218 – Report issued in November 2019

Mrs A complained that Cardiff and Vale University Health Board ("the Health Board") did not take into consideration all relevant historical information when making their decision that she did not show evidence of ADHD and did not require a further assessment for ADHD.

The assessment found that the Health Board had not provided Mrs A with a sufficiently in depth explanation of their rationale when considering their decision including what historical information was considered, what diagnostic criteria were considered, and why they decided that she did not meet the threshold for requiring a further ADHD assessment.

The Health Board has agreed to provide Mrs A with details of the information taken into account by the multi-disciplinary team (MDT) in reaching its conclusion including the applicable criteria and the rationale upon which the decision was based. This will be completed by way of a clinic appointment to take place no later than the end of February 2020.

Malpas Brook Health Centre - Clinical treatment outside hospital Case Number: 201904089 – Report issued in November 2019

Ms A complained that the Health Centre:

1. Failed to appropriately monitor and treat her high blood pressure in a timely manner which resulted in her hand operation being cancelled and put her at risk of heart attack and stroke.
2. Failed to speak to her or look into her notes before deciding that co-codamol would not be provided on repeat prescription in December 2018 which left her without pain relief medication over the Christmas period.
3. Failed to handle her complaint in line with the NHS (Concerns, Complaints & Redress Arrangements) (Wales) Regulations 2011.

The Ombudsman found that the decision to monitor Ms A's blood pressure rather than treating it straight away, the frequency of blood pressure checks, and the decision to start treatment were undertaken in a timely manner and within the range of appropriate clinical management.

The Ombudsman also found that it was not appropriate to reject the repeat prescription, and that there had been a delay in providing a response to Ms A's complaint.

The Ombudsman contacted the Health Centre and it agreed to:

- a) Within 20 working days, review their repeat prescription procedure regarding declining medication to consider providing patients with a small supply of medication and request for them to arrange an appointment to review their medication when it is unclear why they are prescribed the medication.
- b) Apologise to Ms A in writing within 10 days for not providing a repeat prescription of co-codamol, including the rationale behind the GP's decision not to issue the repeat prescription, and an explanation of the new process, proposed by the GP, regarding declining medicine requests (as above).
- c) Apologise to Ms A in writing within 10 working days for the delay in responding to her complaint, including an explanation for the delay.

Vale Group Practice - Clinical treatment outside hospital

Case Number: 201903383 – Report issued in November 2019

Miss X complained that the GP Practice failed to adequately deal with the complaints that she raised. The Ombudsman found that the Practice did not provide Miss X with a written response to the complaint that she raised.

The Ombudsman contacted the Practice and it has agreed to:

Provide Miss X with a written response to her concerns, to include:

- a) A formal written response to the complaint issues raised, including whether each complaint is upheld or not upheld and the rationale for that decision.
- b) Apologies in respect of those heads of complaint which are upheld.
- c) Details of the action points that have been completed (and when/how this was so) together with the details of those that are going to be taken, with timescales for their completion.

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

The Stables Medical Practice - Clinical treatment outside hospital

Case Number: 201904115 – Report issued in November 2019

Ms W complained that the Practice did not provide a timely and comprehensive response to a complaint made about her treatment. She said that she further experienced difficulties in contacting the Practice to raise concerns about their response, and when she eventually received a second reply, it still did not answer her questions.

The Ombudsman found that the Practice had failed to act in accordance with the NHS Wales Putting Things Right complaints guidelines in their management of Ms W's complaint. They had also not fully addressed all of Ms W's concerns in their responses to her complaint.

The Ombudsman contacted the Practice and it agreed to:

Within 20 working days:

- (a) Provide Ms W with a written apology for the poor handling of her complaint and the subsequent communication difficulties.
- (b) Provide Ms W with a further detailed response, addressing all outstanding aspects of her complaint.
- (c) At the next practice meeting or **within the next 4 weeks**, staff would be reminded of the complaints handling procedure, with reference to the NHS Wales 'Putting Things Right' guidelines.

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

Cae Teg Health Centre – Fairwater - Clinical treatment outside hospital

Case Number: 201904123 – Report issued in November 2019

Miss A complained that the Practice did not provide a comprehensive response to a complaint she made about her treatment.

The Ombudsman found that the Practice had not provided a written response to Miss A which addressed all points of her complaint.

The Ombudsman contacted the Practice and it agreed to:

Within 20 working days

- a) provide Miss A with a further detailed response, addressing all outstanding aspects of her complaint.

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

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

[Case Number: 201904325 – Report issued in November 2019](#)

Mr S complained that following him suffering an acute stroke, Betsi Cadwaladr Health Board did not offer him medical support when he needed it most. Mr S had complained to the Health Board, but he did not feel that their response addressed all aspects of his complaint and had unanswered questions.

The Ombudsman found that the complaint response provided by the Health Board had failed to address four key aspects of Mr S's complaint.

The Ombudsman contacted the Health Board and it agreed to:

Within 20 working days:

- a) provide a response to the four outstanding issues which were not addressed in their original complaint reply.

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

[Welsh Ambulance Services NHS Trust - Ambulance Services](#)

[Case Number: 201904681 – Report issued in November 2019](#)

Mr X complained that Welsh Ambulance Services NHS Trust ("WAST") had not responded to the complaint made to it in August 2019 in relation to a 9 hour delay in the attendance of an ambulance for his elderly grandmother who had fallen.

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

- a) To issue its response addressing Mr X's concerns within 4 weeks of the date of receipt of the medical records, or by no later than 31 January 2020, whichever is sooner.

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

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

[Case Number: 201904538 – Report issued in November 2019](#)

Mr X complained that Betsi Cadwaladr University Health Board ("the Health Board") had not provided its final response in relation to a breach of care and treatment provided to the late Mr C whilst he was a patient at Wrexham Maelor Hospital. The Health Board issued its interim response under the NHS complaints procedure "Putting Things Right" (PTR) on 25 April, but Mr X complained that he has not received any communications since this date.

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

By 10 December 2019:

- a) The Health Board will write to Mr X with an update outlining the proposed action to be taken and the timescale to complete the Putting Things Right ("PTR") process.

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

[Welsh Ambulance Services NHS Trust - Ambulance Services](#) [Case Number: 201904658 – Report issued in November 2019](#)

Mr H complained that the Trust had failed to provide an adequate response to his 999 calls after his wife collapsed at home. The Ombudsman noted that the Trust had attended a meeting to address Mr H's concerns but was concerned that it had not provided a formal written response in compliance with the Putting Things Right complaints process. In the absence of this, the Ombudsman was not able to determine whether the Health Board's response was adequate.

In response to the Ombudsman's concerns, the Trust agreed to provide Mr H with a final written response under the Putting Things Right complaints process within 6 weeks of the date of the settlement letter. The Ombudsman considered that this action would provide a further opportunity to resolve Mr H's concerns and that it was appropriate to settle the complaint on this basis.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201904187 – Report issued in November 2019](#)

Mr C complained that the Health Board had failed to provide adequate care to his late wife at Bangor Hospital between 5 August – 15 September 2018. Mr C complained that nursing staff had failed to ensure that his late wife's needs were met in relation to food and drink, comfort and dignity. He also told the Ombudsman that he was not given sufficient information about treatment plans and that he had concerns that the Health Board should have made a diagnosis of sepsis sooner.

The Ombudsman noted that the Health Board had arranged a meeting to address Mr C's concerns but was concerned that it had not provided a formal written response in compliance with the Putting Things Right complaints process. In the absence of this, the Ombudsman was not able to determine whether the Health Board's response was adequate.

In response to the Ombudsman's concerns, the Health Board agreed to provide Mr C with a final written response under the Putting Things Right complaints process within 6 weeks of the date of the settlement letter.

The Ombudsman considered that this action would provide a further opportunity to resolve Mr C's concerns and that it was appropriate to settle the complaint on this basis.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201904083 – Report issued in November 2019](#)

Mr P complained that the Aneurin Bevan University Health Board ("the Health Board") was unable to provide specialist care in relation to a problem that developed with his daughter's PEG feeding tube during a family holiday. Mr P and his family strongly disagreed with the Health Board's position that it had offered his daughter the option of remaining at Nevill Hall Hospital ("the First Hospital") for further treatment. Mr P complained that his daughter was given no option but to agree to discharge from the First Hospital and to travel to her local hospital in Brighton ("the Second Hospital") for further treatment. Mr P told the Ombudsman that he felt this course of action was unsafe. The Ombudsman was concerned that the Health Board's response had not acknowledged or addressed the strength of the family's concerns in relation to his daughter's discharge from the First Hospital.

In response, the Health Board agreed to provide Mr P with an amended response within two weeks, specifically addressing the following concerns:

- a) that Mr P and his family had stated that Mr P's daughter was not offered the option of remaining at the First Hospital on the afternoon of 18 August 2019, prior to her discharge
- b) that Mr P and his family had stated that they were not in agreement with the registrar's plan for discharge on 18 August and did not believe it was in Mr P's daughter's best interests.

The Ombudsman considered that the above action represented a reasonable settlement to the case.

[NHS Business Services Authority - Funding](#)

[Case Number: 201903687 – Report issued in November 2019](#)

Mr S complained that the NHS Business Services Authority ("NHSBSA") did not respond appropriately to his request for a review of a penalty charge which he incurred in relation to a claim for free dental treatment. Mr S told us that he had complained to the NHSBSA that his dental practice had given him incorrect advice in relation to the claim form and that the dental practice had also contacted the NHSBSA to confirm this. Mr S complained that the NHSBSA did not carry out a review of the penalty charge and later applied a surcharge.

Following correspondence with the Ombudsman, the NHSBSA issued a formal response to Mr S's complaint and carried out a further review which resulted in the cancellation of the penalty charge and surcharge. In addition, the NHSBSA agreed to undertake the following actions within 20 working days:

- a) to make a payment of £50 for time and trouble to Mr S in respect of the failures in its response to his complaint
- b) to update its complaints procedure to reflect the fact that complaints relating to Wales may be subject to the jurisdiction of the Public Services Ombudsman for Wales

The Ombudsman considered that the above actions represented a reasonable resolution to the complaint.

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

[Case Number: 201904141 – Report issued in November 2019](#)

Mr X complained about mental health support and services provided by Hywel Dda University Health Board to his wife. In particular, that Care and Treatment plans had not been prepared and his wife had only been seen twice in over a year.

The Health Board provided copies of plans which had been prepared, but it was unable to evidence when these had been provided to Mr X and his wife. Support and services appeared to have been provided broadly in accordance with the plans, but the Health Board acknowledged that some parts of the plans had not been implemented and there had been a gap in services being provided between September 2018 and February 2019, due to staff illness.

The Health Board agreed to provide copies of Care and Treatment Plans prepared since May 2017 and a written explanation as to the how the current plan will be delivered within 20 working days. The Health Board also agreed to provide a written explanation and apology for the "gap" in services together with details of the steps taken to avoid recurrence, also within 20 working days.

The Ombudsman's view was that the above action was reasonable to settle Mr X's complaint.

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

[Case Number: 201904270 – Report issued in November 2019](#)

Mr X complained about the Health Board's handling of his complaint. He said that he had submitted a complaint to the Health Board in May 2018 regarding the care and treatment that his late Grandmother

received during her admission to a hospital within the Health Board's area. The Health Board had issued its response in October 2018, but whilst he remained concerned he sent a follow up letter dated 27 January 2019. Mr X complained that the Health Board had failed to respond to this letter.

The Ombudsman noted that the Health Board complaints procedure did not specify a timescale by which the Health Board had to respond to follow up letters. However, he was concerned that the Health Board had not finalised its response which had inevitably caused Mr X disappointment. The Ombudsman considered that the Health Board should issue its response as soon as possible.

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

- a) Provide a written response to Mr X's letter of 27 January 2019 within 14 working days from the date that the Ombudsman issued his decision.

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

Case Number: 201904195 – Report issued in November 2019

Mrs X complained about the lack of support received from Hywel Dda University Health Board's ("the Health Board's") Mental Health Services, and the unacceptable delay in providing her with the appropriate treatment and/or therapy to deal with her phobias.

The Ombudsman noted that as part of the Health Board's investigation process, it had invited Mrs X to meet the Service Manager and Lead Therapist ("the representatives") at her home to discuss her concerns. However, it was unclear whether Mrs X had agreed to meet the Health Board. After making some enquiries, the Ombudsman found that Mrs X had contacted the Health Board by email to confirm that she wished to accept its offer. The Health Board however, were unaware therefore it took no further action to progress matters whilst it believed it was awaiting confirmation from Mrs X. The Ombudsman concluded that it was still feasible for the Health Board and Mrs X to meet to discuss her outstanding concerns.

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

- a) Initiate contact with Mrs X by telephone, in order to agree a convenient time and date to convene a meeting at her home with relevant representatives of the Health Board in attendance. The Health Board would endeavour to convene the meeting before the end of December 2019.

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

Case Number: 201903240 – Report issued in November 2019

Ms X complained about how the Health Board managed the care of her late father, Mr A, following his admission to hospital due to confusion. Ms X complained that:

- a) Doctors and the Psychiatric Team omitted to see her father.
- b) There were failings in recording information relating to the administration of medication, restraint measures and clinical observations taken.
- c) The Medical Teams failed to ensure that her father was rehydrated and did not monitor his fluid input and output.
- d) The Health Board caused delay in the handling of her complaint.

The Ombudsman found that the issues raised by Ms X had subsequently arisen following the Health Board's initial response to her complaint. Whilst the issues had not been brought to the attention of the Health Board, it had not had an opportunity to respond. The Ombudsman considered that it would be helpful to Ms X to receive a further response.

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

Provide a written response to Ms X regarding the concerns raised in her complaint to the Ombudsman, within 30 working days from the date that the Ombudsman issued his decision.

[Mydentist, Hendy Gwyn Dental Practice - Clinical treatment outside hospital](#)

[Case Number: 201806032 – Report issued in November 2019](#)

Ms X complained that her root canal treatment was not completed in a timely manner and she did not receive appropriate medication during the course of her treatment (Ms X was of the view that Dentist Y should have provided her with antibiotics when her tooth became infected). She was also aggrieved that the Practice told her that she had to source alternative material for her root canal filling.

Ms X said she had a severe latex allergy. The standard material used for filling root canals is made from latex so latex-free material needed to be sourced by the Practice in order for the root canal treatment to be safely completed. Ms X said that due to the lack of treatment she suffered ongoing symptoms and had to pay privately for the treatment to be completed.

In response to the investigation, the Practice acknowledged that there had been a delay in sourcing suitable latex-free material which would have allowed timely completion of the root canal treatment. It said that there needed to be better communication between the dentists and the Practice's administrative team. It recognised that the latex-free filling material should have been ordered before Ms X attended for treatment. It said that further training for staff would be provided going forward to minimise the likelihood of this happening again. It said that Ms X's experience and the procedural failings would be discussed at the next team meeting. It stated that it was very sorry that Ms X found herself in this position and that it was unable to resolve her complaint at the local resolution stage. It indicated that it would be willing to cover the costs of the private treatment she had received to complete the treatment.

The clinical advice obtained during the investigation indicated that the advice provided by Dentist Y regarding treating the infected tooth, without antibiotics, was appropriate and correct. The clinical adviser was of the view that appropriate care had been carried out but that there were regrettable delays in treatment, which the Practice had since sought to remedy.

The only significant failings in this case were, therefore, procedural. As the Practice had acknowledged these and offered appropriate redress, the investigation was discontinued as the complaint had been settled.

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

[Case Number: 201904944 - Report issued in December 2019](#)

Mr A complained that the Health Board had refused to document that his son, B, had characteristics which were consistent with Developmental Verbal Dyspraxia (DVD). He said that despite providing the Health Board with supporting documentation from the Royal College of Speech and Language Therapists, the Health Board said it was not possible for B to have DVD. Further, because of the Health Board's refusal to document the diagnosis, B was missing out on the correct support and provision at school.

The Ombudsman found that there was a difference in professional opinion between B's Speech and Language Therapists (SALT). The SALT appointed by the Local Authority had indicated that she was in complete support of B having a severe speech order, characterised by typical features of DVD.

The Ombudsman contacted the Health Board and it agreed to:

Within 20 working days:

- a) Arrange a properly documented meeting between the Local Authority SALT and the Health Board SALT to specifically discuss the differing opinion in respect of B having characteristics consistent

with DVD. Following the meeting, a written explanation would be provided to Mr A clearly documenting what issues were or were not agreed on, and the reasons for this.

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

[Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures](#) [Case Number: 201904923 - Report issued in December 2019](#)

Mr X complained that the Health Board had failed to respond to the central point of his complaint about the arrangements for his mother's discharge from hospital.

Whilst the Health Board had given a written response to Mr X's complaint, it had not properly addressed this aspect of the complaint. It therefore agreed to give a further written response to Mr X, by 17 January 2020, covering:

- a) The assessment of nursing and care needs prior to her discharge home;
- b) The arrangements for discharge, and the provision of nursing care at home in order to meet her assessed nursing needs;
- c) The discussions and liaison with the family, about the discharge arrangements, prior to and on the day of discharge.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201902933 - Report issued in December 2019](#)

Miss X complained about the care and treatment supplied to her father, Mr Y, by the Health Board from November 2018 until his death in December. In particular, Miss X complained about the appropriateness of treatment with liquid potassium, the decision to stop active treatment and unprofessional staff attitude.

As the Health Board was unable to locate Mr Y's medical records, the Ombudsman could not consider the matter further. The Health Board however agreed to apologise to Miss X and offer a payment of £1000 for this and £200 in respect of delayed complaints handling. The Health Board agreed to remind its staff of the appropriateness of timely responses to complaint investigations.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201904868 - Report issued in December 2019](#)

Ms X complained about the care her mother had received from Aneurin Bevan Health Board ("the Health Board") and the poor communication with the family regarding the severity of her mother's condition. Ms X was unhappy with the response from the Health Board and felt there were still questions concerning her mother's transfer to the Intensive Care Unit ("ICU") that had not been answered.

In settlement of the complaint, the Health Board agreed to provide an additional explanation to Ms X about the clinical assessment her mother received that day and what had changed during the night to warrant the transfer to ICU the following morning.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201904211 - Report issued in December 2019](#)

Dr A and Dr B complained about the fact that they were waiting since March 2019 for a standard response by Betsi Cadwaladr University Health Board ("the Health Board") to a letter responding to concerns that were raised initially in December 2018. The bulk of Dr A and Dr B's original complaint related to their concerns regarding the care their relative, Mrs C, had received.

Following enquiries from the Ombudsman, the Health Board agreed to:

- a) Provide a standard response to the concerns submitted by Dr A and Dr B by 6 January 2020.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201901989 - Report issued in December 2019

Mr X complained about the delay in carrying out an endoscopy after he had attended hospital on both 19 November 2018 and 16 March 2019. Following on from this, he also raised concerns about the length of time that he was kept nil-by-mouth during the first admission to hospital.

During a meeting with Mr X to discuss his outstanding concerns after receipt of the complaint response, the Health Board apologised for his experiences and explained the reasons for the delays. It also, however, identified that there had been a lack of communication with Mr X during both admissions, as he was not kept adequately updated about the clinical situation, and that there was a need a review the pathway for patients presenting to hospital in similar situations.

As a result, and following commencement of the Ombudsman's investigation, the Health Board proposed to offer Mr X an ex gratia payment of £500 in recognition of the inadequate communication that had contributed to the distress, anxiety and inconvenience that he had experienced while waiting for the procedure on 2 separate occasions. It also said that it would remind all relevant clinical staff to keep patients adequately informed of any developments in such situations and to consider alternative care processes if appropriate. Finally, the Health Board said that it would review the pathway for the management of such cases to ensure that it is robust, clinically sound, yet patient centred, and that it would introduce a more robust pathway for these situations if the need was identified after its review. The Ombudsman considered this to be a reasonable settlement and concluded his investigation on this basis.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201903525 - Report issued in December 2019

Mr X complained that the Health Board failed to carry out appropriate investigations into the causes of his symptoms and declined to undertake further neurological testing. Also, when an external review of his care was commissioned, Mr X complained that certain information was not shared with the reviewer and there was a delay in receiving the report.

The Health Board agreed to settle the complaint by taking the following action within 6 weeks:

- a) Arranges an appointment for Mr X to be seen by a Consultant Neurologist not previously involved in his care by the end of January 2020
- b) Provides the Consultant Neurologist with a complete set of Mr X's records (including his radiology records) and copies of the opinions previously provided by Mr X from 2 non-NHS health organisations

The Health Board also agreed to take the following action within 1 month of the neurology review:

- a) The Medical Director should consider the content of the neurology report and seek advice on how best to meet Mr X's needs, and write to Mr X to explain any proposed clinical pathway
- b) The investigation was therefore discontinued as the Health Board's actions resolved the complaint.

Agriculture

Early Resolution or Voluntary Settlement

Welsh Government - Payment schemes

Case Number: 201903392 – Report issued in October 2019

Mr X complained that Welsh Government had failed to determine an appeal he made in August 2018 regarding its decision to reject his Glastir small grant applications for a series of contracts between May and June 2017. The Ombudsman had previously forwarded a complaint made by Mr X about the delay in handling his appeal to Welsh Government, which had apologised for the delay, but confirmed it was not under an obligation to complete the appeal within a particular time.

The Ombudsman found that, although Welsh Government may not have been obliged to complete the appeal within a particular time, it had failed to do so within a reasonable time. Mr X had then been caused inconvenience in complaining to his office for a second time.

Welsh Government accepted its failing to determine the appeal within a reasonable time and agreed to complete the appeal within four weeks. It also agreed to apologise to the complainant and to offer him a payment of £100 to reflect its failing and his time and trouble, also within four weeks. It confirmed that it had no other similar cases which had been awaiting determination for over six months.

Complaints Handling

Upheld

Betsi Cadwaladr University Health Board - Health

Case Number: 201805298 – Report issued in November 2019

Mr K complained about Betsi Cadwaladr University Health Board and the overall care and treatment his father, Mr L, received during two admissions in April and May 2016, in particular its actions following his admission to the Surgical Assessment Unit on 28 April and up to his death on 6 May. Specifically, Mr K was concerned about a missed diagnosis of MRSA, standards of care and cleanliness in the SAU and the circumstances around his father's death. Mr K was also unhappy at the Health Board's delay in providing a response to his complaint and the minutes of two meetings that took place in July 2018.

The Ombudsman's investigation found that the care Mr L received in the SAU between 28 April and 6 May was acceptable and he was reviewed on a regular basis. Mr L had MSSA, not MRSA, and this was dealt with appropriately.

In terms of standards of care and cleanliness, the Ombudsman could not make a finding on this aspect of the complaint as there was insufficient evidence.

The Ombudsman, however, concluded that the events following Mr L's death were unacceptable. Following the end of resuscitation after his cardiac arrest, there was a delay of almost six hours before Mr L's death was certified. During this time, Mr K and his family witnessed Mr L have involuntary movements and spontaneous reflexes such as respiratory movements. As no staff were present to explain why this was happening, Mr K believed that his father was still alive and suffering. Whilst the Ombudsman concluded that Mr L was not alive during this time, the lack of information given to Mr K was unacceptable and left Mr K terribly confused and upset. This part of the complaint was upheld.

The Ombudsman also upheld Mr K's complaint about the delay in the Health Board providing a response to his complaint and the minutes of two meetings that took place in July 2018. The Health Board did not provide Mr K with updates and it was not until the involvement of the Ombudsman that the Health Board finalised its complaint response.

Although not specifically raised by Mr K, the Ombudsman noted that an ECG carried out during Mr L's first admission highlighted probable evidence of coronary artery disease. The Ombudsman also noted that no further action was taken either during this admission or the second admission, but if it had, it might have prevented Mr L's cardiac arrest. However, the Ombudsman could not be certain of this. Nevertheless, this uncertainty was an injustice to Mr K and was enough for the Ombudsman to uphold this aspect of the complaint.

The Ombudsman recommended that Mr K received an apology for the failings identified, and a redress payment totalling £1,000. The Ombudsman also recommended that his report was shared with the staff involved with Mr L's care to facilitate learning in care after death, and that Health Board provided the Ombudsman with any actions arising.

The Health Board agreed to the Ombudsman's recommendations.

[Welsh Government - Care Inspectorate Wales - Childrens Social Services](#) [Case Number: 201805168 - Report issued in December 2019](#)

Mrs X complained about information sharing between Welsh Government – Care Inspectorate Wales (“CIW”) and a Council's Children's Social Services department. In particular, Mrs X complained that information from CIW was not shared with Social Services in a reasonable and timely manner. Mrs X also complained that CIW did not handle her complaint properly.

The investigation found that CIW had not shared information with Social Services in a reasonable and timely manner. It found that CIW had missed an opportunity to share concerns with Social Services in October 2015, which delayed sharing child protection concerns for 8 months without a valid reason. At that point, CIW shared the child protection concerns, but did not provide written evidence it had gathered with Social Services. This caused considerable stress and upset to Mrs X and her family, who believed that the child protection concerns had been dealt with appropriately until they were renewed 18 months later without any apparent trigger, which caused them an injustice. The investigation also found that CIW had not properly addressed Mrs X's complaint for 2 and a half years, and there were other issues with complaints handling.

CIW accepted the findings of the report and agreed to apologise to Mrs X and to pay her financial redress of £500. CIW agreed to provide Mrs X with a copy of the Interim Policy for responding to Safeguarding Events so that Mrs X was aware of the steps taken by CIW to address the areas of concern highlighted. CIW also agreed to pay Mrs X £250 redress in recognition of the poor complaints handling, and to provide evidence that it had put in place an IT system which monitored the provision of timely complaint responses.

[Welsh Government - Care Inspectorate Wales - Childrens Social Services](#) [Case Number: 201804498 - Report issued in December 2019](#)

Miss X complained about information sharing between Welsh Government – Care Inspectorate Wales (“CIW”) and a Council's Children's Social Services department. In particular, Miss X complained that information from CIW was not shared with Social Services in a reasonable and timely manner. Miss X also complained that CIW did not handle her complaint properly.

The investigation found that CIW had not shared information with Social Services in a reasonable and timely manner. It found that CIW had missed an opportunity to share concerns with Social Services in October 2015, which delayed sharing child protection concerns for 8 months without a valid reason. At that point, CIW shared the child protection concerns but did not provide written evidence that it had gathered with Social Services. This caused considerable stress and upset to Miss X and her family, who believed that the child protection concerns had been dealt with appropriately until they were renewed 18 months later without any apparent trigger, which caused them an injustice. The investigation also found

that there had been flaws in CIW's complaint handling process.

CIW accepted the findings of the report and agreed to apologise to Miss X and her son and to pay them financial redress of £500 each. CIW agreed to provide Miss X with a copy of the Interim Policy for responding to Safeguarding Events so that Miss X was aware of the steps taken by CIW to address the areas of concern highlighted. CIW also agreed to pay Miss X £250 redress in recognition of the poor complaints handling.

Early Resolution or Voluntary Settlement

Cardiff and Vale University Health Board – Health

Case Number: 201904286 – Report issued in October 2019

Mr X complained that the Health Board had failed to provide a substantive response to his complaint about the care and treatment it had provided to him.

During his enquiries the Ombudsman established that the Health Board had closed Mr X's complaint in error. The Health Board offered to pay Mr X a sum of £250 and to respond to his complaint. Further to the Ombudsman's enquiries, the Health Board agreed to complete the following in settlement of Mr X's complaint by 19 November 2019:

- a) Provide a written apology to Mr X for the delay in responding to his complaint
- b) Provide an explanation for the delay
- c) Provide a PTR response

Pay Mr X a sum of £250 for the time and trouble in bringing his complaint to the Ombudsman.

Betsi Cadwaladr University Health Board – Health

Case Number: 201903098 – Report issued in October 2019

Ms X complained that the Health Board had failed to answer some concerns she had raised about the care provided to her son before he took his own life.

The Ombudsman noted that whilst an investigation had taken place under the Serious Incident Review Process, it had not issued a formal Putting Things Right ("PTR") response.

The Health Board agreed to undertake the following in settlement of this complaint **by 4 November 2019**: -

1. Apologise to Ms X for failing to issue a PTR response.
2. Issue its PTR response.

Neath Port Talbot Council - Childrens Social Services

Case Number: 201904067 – Report issued in October 2019

Mr X complained that despite requesting for his complaint about Social Services to be progressed to Stage 2, the Council had not escalated it.

The Council said in order to avoid the need for a Stage 2 investigation, it had been continuing to work with Mr X by having regular meetings with him, however, in settlement of Mr X's complaint the Council agreed to issue Mr X with a Stage 2 response letter within the next **30 working days**.

Swansea Bay University Health Board – Health

Case Number: 201900962 – Report issued in October 2019

Mr A complained about the care and treatment provided to his late wife by Swansea Bay University Health Board. Specifically, Mr A complained that Mrs A's scan results were misrepresented, that there was an unnecessary delay in the provision of wound care treatment and that her pain relief medication was not appropriately managed during a later period of admission.

The Ombudsman found that there was an absence of records detailing the discussions which occurred relating to both the scan results and the delay in wound care treatment making it difficult to ascertain the nature of discussions held between the clinicians and Mr and Mrs A at the time. The absence of such records was considered to be evidence of maladministration. In response to the Ombudsman's investigation Swansea Bay University Health Board accepted that Mr A's complaints about the pain medication management identified a failing in the care and proposed a redress settlement under the NHS (Wales) Putting Things Right Regulations and Redress scheme.

In view of the Ombudsman's findings Swansea Bay University Health Board agreed to provide Mr A with an apology and explanation for the examples of poor records management identified and to make a payment of £250 for the time and trouble taken by Mr A to pursue these complaints.

Swansea Bay University Health Board also agreed to liaise with Mr A directly concerning the proposed redress settlement.

Swansea Bay University Health Board - Health

Case Number: 201904636 – Report issued in November 2019

Mr B complained that he was misdiagnosed by Swansea Bay Health Board several years ago. He said that as a consequence of his diagnosis, he had suffered adversely in a number of ways. Whilst he had raised his concerns with the Health Board, he felt that their response letter was unreasonably unsubstantial, and he was unhappy with the level of explanation provided.

Upon reviewing the complaint letter submitted to the Health Board by Mr B in June 2019, the Ombudsman found that its content was very brief in comparison to the very detailed complaint letter submitted to his office. It appeared that the Health Board had not been made aware of the serious nature of Mr B's concerns and had not been afforded the opportunity to provide a comprehensive response.

The Ombudsman contacted the Health Board and it agreed to:

- Consider the full extent of Mr B's complaint and provide him with a comprehensive response in accordance with the NHS Wales 'Putting Things Right' guidelines.

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

Aneurin Bevan University Health Board – Health

Case Number: 201904764 – Report issued in November 2019

Ms J complained that the Health Board had not responded to her complaint in a timely manner. The Ombudsman was concerned that the Health Board had indicated in April 2018 that they would provide a formal response within 6 months but that they had not done so by November 2018. In response to the Ombudsman's enquiries, the Health Board confirmed that they would provide a full response to Ms J's concerns in compliance with the Putting Things Right Process by 6 December 2019.

The Ombudsman considered that this action represented a reasonable settlement of the complaint.

Betsi Cadwaladr University Health Board - Health

Case Number: 201904162 – Report issued in November 2019

Mr A complained that a District Nurse employed by the Health Board had spoken with him on the telephone after he had been referred to that team by his local renal unit. He complained that the nurse had been dismissive in her attitude towards him and had failed to visit him at his home to treat his condition.

Mr A also complained about the delayed response to his complaint by the Health Board and that its response lacked evidence of tracing the nurse responsible and providing her with appropriate advice.

The assessment found that there was a lack of detail regarding tracing the nurse concerned. It also found that the delay in responding to his complaint appeared to have been caused as the letter from the Health Board had not been received by Mr A. There was no evidence to suggest that this was a service failure by the Health Board. It provided him with a copy of the original response letter in a further response letter to him on 30 September 2019, when it became aware that he had not received it.

The Ombudsman contacted the Health Board and it confirmed that the nurse in question had been traced and spoken to regarding the issues complained of by Mr A.

It agreed to:

- 1) Write a letter to Mr A confirming that the District Nurse concerned had been identified by it and spoken to regarding the incident.

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

Hywel Dda University Health Board - Health

Case Number: 201903984 – Report issued in November 2019

Miss X complained on behalf of her mother about the Health Board's failure to keep her informed throughout the complaint process and about its failure to provide her with a response to her complaint.

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

- a) Issue a meaningful apology and an explanation for the delay;
- b) Provide financial redress in the sum of £200 for the time and trouble in pursuing the complaint and in acknowledgement of the poor complaint handling;
- c) Ensure that the above and final response is sent to Miss X by 28 November.

Pembrokeshire County Council - Adult Social Services

Case Number: 201901214 – Report issued in November 2019

Mr X complained that the Council disregarded his concerns about the quality of the care and services his late mother (Mrs Y) received at a Care Home and that the Council therefore failed to adequately safeguard her.

The investigation found that, due to an administrative error Mr X's complaint was not forwarded to relevant officers for a response. Mr X received a response following his telephone call to the Council some months later and after his mother had sadly died. The administrative error caused a missed opportunity to assess the appropriateness of Mrs Y's placement at the Care Home prior to her death. The uncertainty caused by this is an injustice.

The Council agreed to provide Mr X with a written apology and financial redress in recognition of the failings identified. It also agreed to provide evidence that it has reviewed its complaint handling

procedure and to outline the steps taken as a result of that review.

Betsi Cadwaladr University Health Board – Health

Case Number: 201905108 - Report issued in December 2019

Mrs X complained that the Health Board had failed to respond to her letter of 21 October 2019, which she sent following its PTR response. During his enquiries, the Ombudsman established that the Health Board had not acknowledged Mrs X's letter. Further to the Ombudsman's enquiries, the Health Board agreed to complete the following in settlement of Mrs X's complaint by 31 January 2020:

- a) Provide a written apology to Mrs X for the failure to acknowledge her letter
- b) provide an explanation for the delay
- c) provide a written response.

Betsi Cadwaladr University Health Board – Health

Case Number: 201904461 - Report issued in December 2019

Mr D complained that the Radiologist who carry out an ultrasound examination on a lump on his back had failed to communicate with him correctly. This had caused him anxiety as he was unsure what the results had revealed about the nature of the lump. He had also been left without clarity regarding any further investigations or proposed treatment. He contacted the relevant department a few days after his examination and was advised that the Radiologist would contact him. She did not do so. His General Practitioner surgically removed the lump a short time later.

He complained to the Health Board and he was unhappy with its response and the thoroughness of its investigation. He was also unhappy with the delays in responding further to his queries regarding its response letter.

The Ombudsman found that the issues raised in the complaint appear to be justified and there was a lack of clarity and some contradictory responses in both response letters issued by the Health Board in response to his complaint.

The Ombudsman contacted the Health Board and it agreed to:

- a) Write a letter to Mr D apologising for the length of time taken to respond to the outstanding issues raised by him following the Health Board's initial complaint response letter; and
- b) Confirm whether the ultrasound scan results were reviewed by the second Consultant with an explanation of how this was done.
- c) Clarify the discrepancies in the response letters regarding the assurances provided by the Doctor during the ultrasound examinations.
- d) Offer a redress payment of £150 to the complainant for the time and trouble taken to pursue his complaint.

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

Education

Early Resolution or Voluntary Settlement

Flintshire County Council School Transport - School Transport

Case Number: 201903581 – Report issued in November 2019

Mrs X complained that Flintshire County Council (“the Council”) had refused to provide free

school transport for her son as he was not attending the closest secondary school to their home. Mrs X complained about the way in which the distances were calculated and that different distances had been provided by different departments of the Council. Mrs X further complained that the Council's complaint process was not sufficiently independent and that she had been asked to provide a summary of her appeal.

The Ombudsman concluded that the distances had been calculated in accordance with the Council's policy. Although there was a discrepancy in the distances provided by the School Admissions and Integrated Transport departments, the closest school remained the same. The Ombudsman concluded the complaint process was sufficiently independent and that the request that Mrs X summarise her appeal was not unreasonable.

The Council agreed to undertake enquiries with its software provider to establish why there was a discrepancy in the distances and to provide a written response/explanation to Mrs X. In the event that those enquiries concluded that the decision to refuse free school transport may have been incorrect, the Council agreed to reconsider the application and provide appropriate recompense for the travel costs incurred since the start of the academic year if the decision was overturned.

The Ombudsman's view was that the above action was reasonable to settle Mrs X's complaint.

Finance and Taxation

Early Resolution or Voluntary Settlement

Bridgend County Borough Council – Other
Case Number: 201904996 – Report issued in December 2019

Mr L complained that the Council had not granted him the council tax exemption he believed he was entitled to. He said that the fact the previous owner of the property had benefited from the exemption appeared to be unfair. Further, as he had been required to pay council tax, he had suffered financial loss which had delayed the refurbishment of the property.

The Ombudsman found that the Council had made an error when it awarded the council tax exemption. Consequently, Mr L had not been awarded the full exemption period that he was entitled to receive for a dwelling undergoing structural alteration.

The Ombudsman contacted the Council and it agreed to:

Within 20 working days:

- a) Award a further 6 month exemption to Mr L's council tax account, to increase the Class A exemption to a period of 12 months.

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

Housing

Early Resolution or Voluntary Settlement

Linc-Cymru Housing Association - Repairs and maintenance (inc dampness/improvements and alterations eg central heating, double glazing)

Case Number: 201903106 – Report issued in October 2019

Ms A complained that the Association had failed to comply with its own policies as it did not commit to repairs in her home.

When assessing Ms A's complaint it was noted that various issues had been raised with the Association, some of which had not been resolved. The Association had agreed to undertake a home assessment/inspection to determine what remained outstanding. This took place on 1 October 2019.

Powys County Council – Other

Case Number: 201902938 – Report issued in October 2019

Mr X was a Council tenant. He complained about the amount of service charge levied for sewerage. He considered that the Council should offer a discounted rate for disabled persons and/or those in receipt of benefits.

The Council accepted that it had not set out or explained the service charge as it should have done in accordance with the Housing Act (Wales) 2014. In recognition of this failure and the injustice caused to the complainant by being unaware of this information at the start of the tenancy, the Council agreed to apologise and pay him £75 within twenty working days.

The Council also agreed to provide an explanation to the Ombudsman within twenty working days for its failure to comply with the changes introduced by the Act regarding service charges. Finally, the Council agreed to amend its tenancy agreements so that service charges were clearly spelt out for tenants at the start of their tenancies (within two months).

Although the Ombudsman could not consider the amount of the service charge levied by the Council or whether any discount should be offered, information was provided to the complainant about bodies that could consider those matters.

Hafod Housing Association - Neighbour disputes and anti-social behaviour

Case Number: 201903434 – Report issued in November 2019

Mr X complained that Hafod Housing Association ("the Housing Association") had not provided mediation in an attempt to resolve ongoing issues with his neighbour.

The assessment found that whilst Mr X had been informed that the Housing Association did not consider mediation to be appropriate, they had not provided him with updates regarding their view on the suitability of mediation to help resolve the ongoing issues with his neighbour.

The Housing Association agreed that within 10 working days they would meet face to face with Mr X to:

- a) explain why mediation has not been offered to date;
- b) provide an update about their current position in relation to the suitability of mediation to resolve the issues with your neighbour; and
- c) confirm that mediation has not been ruled out as a way to resolve the issues with your neighbour.

The Housing Association will also provide the information in a follow up letter within 5 working days of the face to face meeting.

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

Case Number: 201903007 – Report issued in November 2019

Mr A complained that United Welsh Housing Association had failed to repair a leak at his property in a timely manner which caused damage to the flooring. He felt that the proposed repair to the flooring was unacceptable. Mr A also complained that the Housing Association had not handled his complaints in an acceptable manner.

The Ombudsman found that there had been a delay in the Housing Association undertaking the repairs and it had been unreasonable in its approach to repair the damage caused. Additionally, the Ombudsman found that the Housing Association had not acted in accordance with its complaints handling policy in its management of Mr A's complaints.

The Ombudsman contacted the Housing Association and it agreed to:

Within 20 working days:

- (a) Contact Mr A to arrange replacement of all tiles in the hallway to the same cosmetically acceptable standard that they were before the water damage occurred.
- (b) Apologise and pay Mr A the sum of £125 in reflection of the poor complaint handling.
- (c) **Within 20 working days** of agreeing the replacement with Mr A, undertake the repair work.

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

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

[Case Number: 201904204 – Report issued in November 2019](#)

Ms S complained that Cardiff Council had made a number of errors and omissions in their response to a complaint made to them in respect of their Housing Options and Housing Appeals departments. The Ombudsman found that the Council had not been provided with the observations made by Ms S following their complaint response and therefore had not been afforded the opportunity to respond to them.

The Ombudsman contacted the Council and it agreed to:

Within 20 working days

- a) provide a full response to the comments and further questions raised in response to their complaint investigation letter issued 1 October 2019.

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

[Cardiff Council - Other](#)

[Case Number: 201903997 – Report issued in November 2019](#)

Mrs X complained that Cardiff Council ("the Council") were removing a wall at the back of her property and replacing it with a fence. The Council had taken advice on the status of the wall and had determined it was not a shared wall and they indeed own it. Mrs X was concerned that the Council had not considered the potential subsidence and effect this would have on her property if they removed the structure. She wanted to see a surveyor's report to verify that removing it would not damage her property.

In settlement of the complaint the Council has agreed to instruct an independent surveyor to record the condition of Mrs X's property and share this report with her. The Council have agreed to undertake this action within the next 30 working days, dependent on the surveyor's availability.

Grwp Cynefin - Repairs and maintenance (inc dampness/improvements and alterations eg central heating, double glazing)

Case Number: 201904037 – Report issued in December 2019

Miss X complained that Grwp Cynefin (“the Association”) had replaced the heating system in her property in October 2018 and since that time her energy bills had significantly increased, and she was now in fuel poverty.

In making enquiries with the Association, the Ombudsman was informed that Miss X had complained about the matter and had been given an opportunity to appeal the Association’s decision letter of July 2019 but this not had been utilised. In settlement of the complaint, the Association agreed to an appeal and will within the next 30 working days conduct a full Stage 2 investigation of the complainant’s concerns and issue a detailed response.

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

Case Number: 201904131 – Report issued in December 2019

Mrs A complained that Charter Housing Association (“the Association”) had failed to attend to several issues she had reported to it regarding the house where she lived as one of its tenants. This included defects to drainage in the garden as well as internal fixtures and structural issues. She had moved into the property in July 2017 and had reported several problems since that date.

The Ombudsman considered her complaint and used his discretion to assess issues raised in Mrs A’s complaint from June 2018. This date was approximately 12 months from the date she made an official complaint to the Association about its failure to address the defects she had reported to it. The Association had responded to her complaint by letter on 20 August 2019 following a visit to her home by a surveyor employed by it on 19 July 2019. It had apologised for some delays in responding to repair requests. It had also agreed to resolve any outstanding defects.

The Ombudsman was concerned, however, that there appeared to have been no update provided by the Association to Mrs A regarding the outstanding repairs required. He contacted the Association and it agreed to;

- a) Write a letter to the complainant outlining the current progress of any outstanding repair issues listed in its response letter to her, dated 20 August 2019, with an estimated date of completion.
- b) Offer a payment of £150 for time and trouble taken to report several issues regarding her rented property since September 2018.

This would need to be completed within 30 working days of the date of the decision letter.

The Ombudsman believes that this will provide a resolution to Mrs A’s complaint.

Cardiff Council - Applications, allocations, transfer and exchanges

Case Number: 201904520 – Report issued in December 2019

Mr A complained that he had submitted further medical evidence to Cardiff Council (“the Council”) in support of his housing transfer application and that it failed to provide him with an update on his current position on the housing register.

The Council agreed to undertake the following action within 20 days to resolve Mr A’s complaint:

- a) To set out in writing that the medical evidence has been fully considered
- b) To confirm which priority band the housing application is in.

Planning and Building Control

Upheld

Flintshire County Council - Other planning matters

Case Number: 201807248 – Report issued in November 2019

Mrs X complained about the delay in Flintshire County Council installing a fence that it had agreed to provide in February 2017. Mrs X also said that the Council failed to handle her complaint in accordance with its own complaints procedure. In particular, she complained that the Council had failed to adhere to the deadlines for issuing its complaint responses or provide her with appropriate updates for the delays.

The Ombudsman found that, whilst some of the delays with the arrangements to install the fence were not necessarily unreasonable or within the Council's control, a significant delay had been caused by the incorrect assumption that Mrs X had moved properties and so no longer required the fence. As a result, there was a failure to inform Mrs X of the outcome of the planning application for the fence as previously advised and to make arrangements for a contractor to install it. The Ombudsman therefore concluded that it was unacceptable that Mrs X had to wait almost 2 years for the installation of the fence that the Council had offered in February 2017. He also found that the Council's Step 2 complaint response in particular had been issued far in excess of the relevant timescales and that Mrs X had not been provided with timely or meaningful updates on when the Council would be in a position to respond to her. As a result, the Ombudsman upheld both complaints.

The Ombudsman recommended that the Council apologise to Mrs X and make her a redress payment of £500 to reflect the failings that he identified. He also recommended that the Council remind staff involved in complaint handling that complainants should be provided with timely and meaningful updates if it is not possible to issue a complaint response within the Council's timescales. Furthermore, given the comments that he had received from the Council during the investigation about the improvements that it had implemented in complaints handling for the Planning, Environment and Economy department, the Ombudsman recommended that the Council provide evidence of these improvements (or, if these have not yet been implemented, of the actions that it is taking to address the issue). Lastly, he recommended that the Council reviews the performance of the department in responding to complaints. The Council agreed to implement the recommendations.

Early Resolution or Voluntary Settlement

Carmarthenshire County Council - Unauthorised development - calls for enforcement action etc

Case Number: 201904044 – Report issued in November 2019

Mr X complained about the failure by the Council to take enforcement action against the developer who built his son's home, the garden of which had been built other than in accordance with the approved plans. Mr X also complained about the way in which the Council had dealt with his formal complaint.

The Ombudsman found that although the Council belatedly provided its rationale for deciding against enforcement action, Mr X had been put to avoidable time and trouble in pursuing his complaint. Whilst the Ombudsman could not question the merits of the substantive decision the Council had made regarding enforcement action, he concluded that the delay in providing its rationale and the generally poor standard of its complaints handling represented an unresolved injustice to Mr X.

In settlement of the complaint, the Council agreed, within 20 working days, to apologise to Mr X and pay redress of £250, in recognition of the avoidable time and trouble to which he had been put in pursuing his complaint.

The Ombudsman considered these actions to be an appropriate resolution.

Social Services - Adult

Upheld

Pembrokeshire County Council - Social Care Assessment

Case Number: 201806802 – Report issued in November 2019

Mrs X, who had been diagnosed with a terminal condition, complained that Pembrokeshire County Council ("the Council") did not assess her needs for care in a timely manner, did not provide her with support to meet her needs in a timely manner and did not give proper consideration to her personal circumstances. Mrs X also complained that the Council did not handle her complaint properly.

The investigation upheld all four aspects of Mrs X's complaint. It found that Mrs X's needs for care were not assessed within the Council's own timescale for non-critical assessment, even though she was terminally ill. It found that as a result, Mrs X was not provided with support to meet her needs in a timely manner or, in fact, at all. This caused a significant injustice to Mrs X who was left to manage without support.

The investigation found that the Council should have taken into account Mrs X's personal circumstances, particularly her terminal condition, and expedited her assessment. It did not do so. The Ombudsman found that this was a service failure which caused significant injustice to Mrs X and engaged her rights under Article 8 of the Human Rights Act because she was not able to live her life as independently as possible for as long as possible. The investigation also found that the delay in providing a complaint response to Mrs X was a service failure, and perhaps the clearest indication that the Council did not take into account Mrs X's diagnosis.

The Council agreed to apologise to Mrs X and offer her a full integrated assessment. It also agreed to undertake training of the relevant team, to audit and amend relevant policies as required, and to take the case to its Equalities and Human Rights officer for review and identification of learning points.

Early Resolution or Voluntary Settlement

Denbighshire County Council - Social Care Assessment

Case Number: 201904876 – Report issued in December 2019

Mr R complained that the Council's Social Services Department failed to take a proactive role in his mother's care at home. He said that, at critical times in his mother's life, communication with them was poor and they failed to meet her needs.

The Ombudsman found that the Council had not investigated Mr R's complaint, submitted to them in September 2019, in accordance with The Social Services Complaints Procedure (Wales) Regulations 2014. The Ombudsman contacted the Council and it agreed to:

Within 20 working days:

- a) Contact Mr R in order to facilitate the commencement of an investigation of his complaint, made to the Council in September 2019, in accordance with The Social Services Complaints Procedure (Wales) Regulations 2014.

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

complaint.

Social Services – Children

Early Resolution or Voluntary Settlement

Vale of Glamorgan Council - Other

Case Number: 201903657 – Report issued in October 2019

Mr X complained that he had made a formal complaint to Social Services and received a Stage 1 response. He had asked for his complaint to be progressed to Stage 2 for an independent investigation. However the Council had refused this request. In settlement of Mr X's complaint the Council agreed to issue Mr X with a Stage 2 response within the next **30 working days**.

Vale of Glamorgan Council – Other

Case Number: 201903186 – Report issued in November 2019

Mr X complained that Vale of Glamorgan Council failed to provide a complaint response to the complaint he raised about Social Services.

The Ombudsman found that the Council had failed to provide Mr X with a complaint response. The Ombudsman sought and gained the Council's agreement to carry out the following action within 20 working days:

- a) Deal with Mr X's complaint in accordance with the Social Services Procedure and provide Mr X with a full complaint response.

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

Swansea Council – Other

Case Number: 201904212 – Report issued in November 2019

Mr X complained that Swansea Council ("the Council") had not progressed his complaint to Stage 2 of the Social Services complaints process.

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

- a) Proceed to escalate Mr X's complaint to Stage 2 of the Social Services complaints process and issue the Stage 2 response in line with the statutory timescales, following the meeting between Mr X and the Independent Investigator.

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

Caerphilly County Borough Council – Other

Case Number: 201904972 - Report issued in December 2019

Mrs B complained that the Council provided her with incorrect information regarding the amount of foster care allowance she would receive. She said that she made the decision to proceed with the fostering arrangement, which was an enormous, life changing decision, based on inaccurate information. Further, the difference in the sum agreed, and the amount actually received, had resulted in a detrimental financial impact on the family. The Ombudsman found that the Council had admitted that Mrs B was given incorrect information, and that this information had been used to inform Mrs B's decision to proceed with the fostering arrangement. By the time Mrs B was made aware of the correct rates, the child was living

with her, and, in her opinion, it was too late for her to change her decision.

The Ombudsman contacted the Council and it agreed to:

Within 20 working days:

- a) Reimburse Mrs B the sum of £1796.56, which represents the difference in the amount she was notified she would receive as a foster carer, and the amount she actually received, for the period prior to her being approved as a foster carer.

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

Flintshire County Council - Safeguarding

Case Number: 201904661 - Report issued in December 2019

Miss X complained about the Council's failure to intervene in her daughter's school, after she complained about bullying. She also complained that the Council had not taken forward her request for child protection action to be taken.

The Ombudsman was unable to consider the majority of Miss X's complaint, as it related to the internal management of the school her daughter attended and so was outside of his jurisdiction. However, the Ombudsman considered that the Council could investigate Miss X's limited complaint about its decision not to progress child protection enquiries. The Council agreed to consider this complaint under the statutory social services complaints procedure. The Ombudsman considered this to represent an appropriate settlement.