

The Ombudsman's Casebook

Issue 40 January – March 2020

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Section 16

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

Cartrefi Cymru & Betsi Cadwaladr University Health Board & Gwynedd Council - NHS Independent Provider/Health/Adult Social Services – Care homes/Other/Services for vulnerable adults (eg with learning difficulties. or with mental health issues)

Case Number: 201806537 & 201806536 & 201806533 – Report issued in January 2020

Mrs M's son, Mr N, suffered from drug-induced psychosis and acquired brain injury. He received a package of care, funded jointly by Gwynedd Council ("the Council") and Betsi Cadwaladr University Health Board ("the Health Board"), and provided by Cartrefi Cymru ("CC"), a registered domiciliary care provider. Mrs M complained about:

- a) the care given to Mr N by CC
- b) failings in communication between the Council, the Health Board and CC, resulting in CC not receiving comprehensive documentation/risk assessments/care plans for Mr N.

Sadly, Mr N choked while eating alone in his bedroom, and died despite first aid being administered by his carer.

The Ombudsman found that the Council and the Health Board jointly funded Mr N's care, with the Council being the lead commissioner. However, despite there being an overarching, general contract with CC for the provision of care, there seemed to be no documentation showing the awarding of the contract and the specific terms relating to Mr N, and the respective responsibilities of the parties. This amounted to maladministration on the part of both the Council and the Health Board. In addition, there was no documentation to show that the Council, as lead commissioner, had monitored the delivery of the service under the contract.

Although the Ombudsman could not say with any certainty that any of the bodies had seen a risk assessment relating to the risk of Mr N choking, CC should have carried out its own choking risk assessment in view of Mr N's obvious vulnerabilities.

The Ombudsman upheld the complaint against all three bodies. However, he did not conclude that any of the failings he identified had caused or contributed to Mr N's death. However, Mrs M would be left with the uncertainty that, but for the failings, things might have been different.

The Ombudsman made the following recommendations:

- a) The Council and the Health Board:
 - 1) Within one month of the issue of the report, both the Council and the Health Board should apologise to Mrs M for the failings I have identified.
 - 2) Within three months of the issue of the report, both the Council and the Health Board should review their respective contract governance arrangements to ensure that contract management is in line with good practice (as contained in the Contract Management Principles and the principles in the Wales Procurement Policy Statement).
- b) The Health Board

- 3) Within three months of the issue of the report, the Health Board should remind staff members with responsibility for managing a service user's Care and Treatment Plan and care package of the need to ensure they comply with the requirements of NICE Clinical Guideline CG136 and the Mental Health (Wales) Measure 2010 and the Mental Health Act 1983 Code of Practice.

c) CC

- 4) Within one month of the final report, CC should apologise to Mrs M for the failing I have identified.
- 5) Within three months of the final report, CC should remind members of staff with responsibility for delivering care plans of the importance of ensuring all relevant assessments are carried out, and the care package reviewed, as soon as possible after being contracted to provide care.

[Flintshire County Council - Environment and Environmental Health - Noise and other nuisance issues](#)
[Case Number: 201900014 – Report issued in January 2020](#)

A Landlord complained that, between 2014 and 2019, Flintshire County Council failed to take timely and appropriate action to deal with a car wash which was causing Statutory Nuisances of noise and water/chemical spray affecting the Landlord's tenant, Mr R and which was also in breach of planning control. The Landlord also complained that the Council failed to investigate and respond to its complaint appropriately and in line with its Corporate Complaints Policy.

The Ombudsman found that despite identifying in 2014 that the car wash was causing a Statutory Nuisance, the Council did not open an appropriate case file until 18 months later and did not serve an Abatement Notice for a further 13 months. When the car wash continued to operate and cause the Statutory Nuisance, contravening the Abatement Notice, the Council took no further action. Consequently, Mr R had to endure significant persistent, disruptive and intrusive noise levels and water spray for a number of years. This was a significant injustice to the tenant and also to the Landlord, in view of the Landlord's obligations to its tenant and his right, under Article 8 of the Human Rights Act 1998, to the quiet and peaceful enjoyment of his home.

The Ombudsman found that the Council was aware from at least 2012 that the car wash did not have appropriate planning consent but it had almost no planning records from before August 2018. There were also failures in inter-departmental communication and co-operation. The lack of records coupled with the Council's inaction over the 5 years preceding August 2018 suggested that it did not fully consider whether to take enforcement action against the car wash and amounted to maladministration. Consequently, the Council could not explain the reasons behind its actions (and inaction) and moreover, it was impossible for the complaint to be dealt with fully and the history of the case in the Planning Department to be examined and evaluated.

The Ombudsman also found that the Council failed to respond to the Landlord's complaints appropriately and escalate them when it asked for assistance to raise a formal complaint. There was also an absence of clearly established ownership at senior levels in the Council, compounded by the length of time that the failures continued and a lack of regard for the difficulties being faced by Mr R. Consequently, there was no appropriate investigation of the complaint and the Landlord received no meaningful response to its concerns.

The Council agreed that, within one month of the Ombudsman's report, it would:

- a) Remind relevant staff at all levels within the Council of the importance of dealing with correspondence appropriately, including signposting individuals who want to raise a formal complaint to the Corporate Complaints Team
- b) Offer a meaningful apology, in writing, to the Landlord along with £1000 financial redress in recognition of the failings in complaints handling, and the Landlord's time and trouble pursuing the complaint for at least 5 years
- c) Offer a meaningful apology, in writing, to Mr R, along with £2,500 financial redress for the failure to deal with the Statutory Nuisances and in recognition of the persistent and prolonged exposure of Mr R to unacceptable levels of noise and water spray for at least 5 years.

In January 2019 the Council reviewed and updated its policy on Planning Enforcement. The Council also agreed that, within 3 months of the Ombudsman's report, it would:

- a) Share this report and its findings with relevant staff in the Planning, Environment and Legal Departments as well as with the Leader of the Council, the Cabinet Member for Planning and Public Protection, the Planning and Development Control Committee and the Environment Overview and Scrutiny Committee
- b) Establish what powers remain available to it to resolve the issues and ensure that it fully exercises those powers as appropriate to achieve an ultimate resolution
- c) Review its Public Protection Service Enforcement Policy, to ensure that it remains relevant, effective and compliant with Welsh Government guidelines, legislation and best practice, with particular reference to Statutory Nuisances
- d) Develop formal procedural arrangements for co-operation between departments to improve the efficacy and efficiency of inter-departmental collaboration, with an emphasis on Planning, Legal and Environmental Health
- e) Review the Complaints Policy to ensure it is clear who should have overall responsibility for investigating and responding to complaints, particularly where the matters concern different departments in the Council
- f) Reflect on how the consideration of human rights can be embedded into its practice when deciding whether to take enforcement action, with particular reference to planning control and investigations into Statutory Nuisances
- g) Review its internal communication and escalation channels to ensure that staff can raise concerns during their day-to-day work which can then be managed constructively, to encourage ownership and accountability whilst discouraging a "blame culture".

[Abertawe Bro Morgannwg University Health Board – Health - Clinical treatment in hospital](#) [Case Number: 201806963 – Report issued in February 2020](#)

Mrs R raised concerns about the care her late mother, Mrs T received from Abertawe Bro Morgannwg University Health Board which, since the time of the events has changed its name to Swansea Bay University Health Board ("the Health Board"). Mrs R complained that on 26 and 27 June 2017 the Health Board failed to take prompt and appropriate action to assess and treat Mrs T's symptoms of a stroke. She also complained that during Mrs T's consequent admission to hospital, the Health Board failed to ensure adequate monitoring and care of Mrs T's fluid balance and nutritional needs, take prompt and appropriate action to investigate the cause of Mrs T's distended abdomen and bowel symptoms, and manage Mrs T's anxiety.

The Ombudsman found that there was no appropriate assessment of Mrs T's risk of a stroke, even when her family raised concerns that she appeared to have a left-sided weakness, facial droop and slurred speech. Furthermore, when doctors were asked to review Mrs T in light of her family's concerns on the 26

and 27 June, two separate clinicians failed to document their attendance, their assessment or their findings and a third noted no reference to whether any symptoms of potential stroke were considered. By the time Mrs T's stroke was diagnosed on the afternoon of 27 June it was too late to administer thrombolytic medication, although it was not possible to say for certain whether this would have limited the damage caused by the stroke or reduced Mrs T's resulting disabilities.

The Ombudsman also found that there were further shortcomings in record keeping throughout the period of care. This made it impossible to determine what food and drink Mrs T consumed and suggested that her fluid balance was unregulated. The Ombudsman concluded that Mrs T was probably malnourished given her significant weight loss during her admission. However, this was not appreciated or addressed because of omissions and errors in the records and Mrs T was not referred to a dietician until 3 weeks after she should have been. It was unclear whether these shortcomings resulted in a significant impact on Mrs T's clinical condition, but they led to worry and frustration for Mrs T's family, who saw that she was not eating and was rapidly losing weight, and to uncertainty as to whether Mrs T's nutritional deficit might have compounded her other symptoms.

The Ombudsman considered that the Health Board took appropriate action to investigate Mrs T's bowel symptoms during her admission. Whilst no specialist advice was sought from a Gastroenterologist, which might have been helpful, it was unlikely that her treatment or management would have been any different even if such a referral had been made. There was no indication that specialist input or investigation was required until 22 August, when Mrs T dramatically deteriorated. However, by the time Mrs T was taken for a stomach X-ray on 23 August, Mrs T was critically unwell. The Ombudsman found there was a failure to reconsider whether to proceed with the X-ray given Mrs T's deterioration and sadly, as Mrs T was being returned to the ward after the X-ray, she died.

Finally, the Ombudsman found that Mrs T experienced severe and prolonged anxiety and was probably suffering from delirium during her admission. The treatment she received for this was, overall, appropriate and the decision not to prescribe ongoing sedatives was acceptable clinical practice, because Mrs T was at high risk of breathing difficulties. However, he felt that specialist input should have been sought. This might have provided some reassurance to Mrs R, who felt that her concerns and her requests for more to be done were being dismissed and ignored. Furthermore, a specialist should have been able to suggest whether there was any other type of medication or intervention available to alleviate Mrs T's anxiety without the associated risks of a sedative.

The Health Board agreed to the Ombudsman's recommendations that, within one month of the date of his report, it should:

- a) ensure that all clinicians involved in Mrs T's care have the opportunity to consider the findings in this report and demonstrate that those individuals whose actions have been criticised have reflected on how they can improve their practice in future
- b) remind all doctors in the Emergency Department and the Medical Assessment Unit of the First Hospital of the importance of documenting their attendance and assessment of patients, as well as any examination findings and outcomes
- c) demonstrate that it has appropriate processes in both the First and Second hospitals to enable ward staff to access specialist input from other specialities
- d) apologise to Mrs R for the failings identified in this report.
- a) The Health Board agreed to the Ombudsman's recommendations that, within three months of the date of his report, it should:
- e) provide evidence that it has adopted an appropriate, recognised stroke risk assessment scoring system and taken action to ensure that all doctors in the Emergency Department, Medical Assessment Unit and the stroke ward of the First Hospital have been informed and trained on how to apply it

- f) review the training records of all doctors in the Emergency Department, Medical Assessment Unit and the stroke ward of the First Hospital, and provide refresher training to those whose training is not up to date on the recognition and treatment of TIAs and stroke, with particular reference to the most recently published NICE guidance
- g) carry out a random sampling audit of patients' nursing records on the stroke wards of both hospitals, with a particular emphasis on completion of nutrition and fluid balance charts and take action to address any identified trends or shortcomings.

Student Loans Company (in respect of functions it performs on behalf of the Welsh Government) – Education - Other

Case Number: 201806342 – Report issued in February 2020

Mr X complained that the Student Loans Company (“the SLC”) failed to inform him that he was not eligible for funding for a tuition fee loan for the 2014-15 academic year in a reasonable and timely manner. He said that the SLC incorrectly asked him for evidence of his personal circumstances in 2015-16 when he was not entitled to additional funding, and did not tell Mr X that his position was such that he would not be entitled to that funding in a reasonable and timely manner. Mr X also complained that the SLC did not handle his complaint in a reasonable and timely way.

The investigation found that the SLC failed to inform Mr X that he was not eligible for a tuition fee loan for 2014-15 in a reasonable way. It found that it should have been known from December 2014 that Mr X was not eligible for a loan, but this was not properly communicated to Mr X until after he had incurred fees for the full academic year, leaving him in considerable debt. The investigation also found that the SLC knew from October 2015 that Mr X would not ever be entitled to additional funding due to his personal circumstances in 2015-16, but that the SLC continued to ask for information about Mr X's personal circumstances, and even (wrongly) granted his application for additional funding, until February 2017, almost 18 months later. This, on top of the debt burden Mr X had already incurred, caused him considerable stress.

The investigation also found that the complaints process had taken almost 2 years, of which a significant amount was attributable to the SLC and an Independent Assessor appointed by the Welsh Government. It also found that the SLC and the Welsh Government's complaint handling process was confusing, noting that the Independent Assessor completed a Stage Three report into Mr X's complaint, but then had to issue an addendum report and an apology for referring to incorrect Regulations. This was stressful and confusing for Mr X, and unfairly raised his expectations that he was entitled to funding, only for him to be disappointed again when the position was clarified.

The SLC accepted the findings of the investigation, and agreed to apologise to Mr X, and pay him £250 redress for the poor complaints handling and £250 for requiring him to enter into unnecessary correspondence regarding his personal circumstances when it knew he was not entitled to funding. The Ombudsman also recommended that the SLC satisfy the debt Mr X had incurred to his University between December 2014 and June 2015 (which he was not properly advised he was incurring), and instead arrange for Mr X to pay the debt back to the SLC on the usual terms and conditions which apply when SLC funding is granted. This would ensure Mr X was in no worse a position than he would have been in had the failings not occurred.

The SLC said that it had already commissioned a review of its complaint handling processes and was in the process of working with the different UK administrations to implement changes. The Ombudsman recommended that as part of the review of its complaint process it should take on board the issues raised by this complaint.

The Welsh Government also agreed to work with the SLC to review the complaints handling process

applicable to students in Wales and to work with the Ombudsman's office to ensure that it complies with the Principles of Good Complaint Handling and any model complaint handling process the Ombudsman issues in his capacity as the Complaints Standards Authority for Wales.

Health

Upheld

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201806371 – Report issued in January 2020

Miss W complained about the care provided to her late sister, Ms S, during the course of 3 admissions to Ysbyty Glan Clwyd and Ysbyty Gwynedd in August and September 2017. Ms S had a history of heart problems and had been referred to a hospital in England for consideration for coronary artery bypass surgery. She was also diabetic and anaemic. She attended the Emergency Department (ED) 3 times, following episodes of collapse and loss of consciousness (syncope). On the first 2 occasions Miss S was admitted to hospital and underwent investigations; she was thought to have cardiac syncope and was referred to the cardiology team, and also to the vascular team for treatment of discolouration to her foot. The third time Ms S attended the ED she was discharged home in the early hours of the following morning. Ms S collapsed again 6 days later, but could not be revived and, sadly, died.

The Ombudsman found that Ms S met the criteria for an implantable cardioverter defibrillator (ICD) on her first admission, but there was no consideration of this, or any attempt to expedite her referral for cardiac surgery. However, overall, he did not believe her treatment would have been different. The Ombudsman also found that there had been delays in referring Ms S to the vascular team and to the cardiology team during her second admission. Ms S should not have been discharged on the third occasion, and should have been referred to the medical/cardiology team. He upheld the complaint.

The Ombudsman recommended that the Health Board apologise to Miss W for the failings, introduce and provide an educational programme on a syncope pathway, develop guidelines for the assessment of diabetic patients in the ED, and ensure that the Consultants involved reflect on his report.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201807784 – Report issued in January 2020

Mrs X complained that, following a diagnosis of Vitamin B12 ("B12") deficiency (this occurs when a lack of vitamin B12 causes the body to produce abnormally large red blood cells that cannot function properly which can cause a wide range of problems) in May 2018 her partner Mr Y, was not prescribed with the correct B12 treatment in accordance with the relevant B12 guidelines. She said this impacted on Mr Y's treatment and potentially contributed to his deteriorating condition. The investigation considered the period of care between May and November 2018.

The Ombudsman found that Mr Y's B12 management was contrary to relevant guidelines. Whilst the incorrect management of Mr Y's B12 was not the cause of his confusion or delirium, and did not cause or contribute to the subsequent diagnosis of Dementia with Lewy Bodies, the Ombudsman found that it contributed to Mrs X's distress at a difficult time and when she had been raising concerns about Mr Y's B12 management. In addition, the result of the incorrect management was that Mr Y's B12 stores remained depleted. The Ombudsman upheld the complaint.

The Health Board agreed to apologise to Mrs X for the identified failings and to share the report with relevant clinicians, using the case as a learning event to highlight the importance of following relevant guidance on B12 management. It also agreed to arrange refresher training for relevant clinicians on the management of B12 deficiency.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201806726 – Report issued in January 2020

Mrs Y complained about the care and treatment her husband, Mr Y, received following hip replacement revision surgery (“the surgery”) in October 2017. She was concerned that there were failings in the surgery (including whether the risk of hip dislocation and a second operation could have been prevented had a different prosthesis been used during the first hip revision operation) and in the management of Mr Y’s mental health, following the surgery, which led to missed opportunities to recognise and treat his delirium sooner.

The Ombudsman found that the surgery was carried out within the bounds of acceptable clinical practice and the components used were clinically appropriate. He did not uphold this complaint.

The Ombudsman found that it was reasonable, based on Mr Y’s history of schizophrenia, to consider psychosis as a diagnosis initially. However, the fact that Mr Y’s mental health had been stable on treatment and he had not had psychotic symptoms before the surgery should have prompted earlier consideration of delirium. Whilst there was no clear, clinical evidence that the failure to diagnose delirium sooner compromised Mr Y’s care, the delay in reaching a diagnosis was a source of concern to Mr and Mrs Y and caused them distress. The Ombudsman upheld the complaint to this extent.

The Health Board agreed to apologise to Mr and Mrs Y for the identified failing and to issue a reminder to relevant staff about the importance of being vigilant for post-operative delirium.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201806111 – Report issued in January 2020

Mr Y complained about the care and treatment provided to his partner, Ms X, by the Health Board relating to the management of her mesothelioma between February 2017 and February 2018. The Ombudsman considered whether there were failings in care which resulted in missed opportunities for earlier treatment / intervention and whether there were failings in the nursing and palliative care provided in January and February 2018.

The Ombudsman found the initial management of Ms X was appropriate and in line with accepted clinical practice and relevant guidance. Evidence in April 2017 was suggestive of mesothelioma but insufficient for a definitive diagnosis or commencement of chemotherapy treatment. However, the development of pleural thickening (thickening of the lung lining) at this time should have prompted consideration of a further biopsy to try and confirm a diagnosis. Whilst this may have resulted in an earlier diagnosis of mesothelioma, it would not have altered the treatment or outcome for Ms X but would have allowed Ms X and Mr Y more time to prepare themselves. In addition, communication at this time with Ms X about her condition was insufficient.

When Ms X was admitted to hospital in January 2018 her treatment was clinically appropriate and in line with guidance. However, the evidence does not support that Ms X was involved in discussions about available treatment options. Whilst various aspects of Ms X’s care were reasonable, the failure to request a repeat biopsy in April 2017, together with shortcomings in communication, represented failings in care which caused both Ms X and Mr Y injustice. The Ombudsman upheld this complaint.

The Ombudsman found that during Ms X’s admission in January and February 2018, the initial and subsequent management of Ms X’s palliative care needs were in line with NICE guidance. However, whilst Ms X received good physical care during her admission, there were shortcomings in communication, both inter-professional communication between the respiratory and palliative care teams and with Ms X which was contrary to guidance and caused Ms X an injustice as she was not given the opportunity to be part of the decision-making surrounding her care. This would have added to Ms X and Mr Y’s distress at a very difficult time and caused uncertainty about whether Ms X could have been referred to the hospice sooner.

The Ombudsman upheld the complaint to this extent.

The Health Board agreed to apologise to Mr Y for the identified failings, refer the report to a meeting of its Quality, Safety & Experience Committee to consider managing patients in accordance with BTS guidelines on mesothelioma and for the report to be shared with all relevant clinicians for learning.

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

[Case Number: 201807328 – Report issued in January 2020](#)

Mr A complained about the care and treatment he received while an inpatient at Ysbyty Gwynedd ("the Hospital") between 6 May and 24 May 2018. He complained that the chest pain he experienced on 6 May was not adequately assessed or treated.

The Ombudsman's investigation concluded that whilst the care provided to Mr A in the Emergency Department was reasonable and appropriate there were shortcomings in Mr A's subsequent inpatient management. In particular, there were shortcomings in communication and there was no system in place to ensure that discharging clinicians reviewed the discharge documentation. As a consequence, there was a missed opportunity for Mr A to have follow-up tests.

The investigation also found that there had been a failure by the Cardiology department to action a later GP referral in a timely manner. The Ombudsman concluded that the shortcomings meant that there was a delay in Mr A receiving the necessary treatment and as a result he had suffered more pain than he might have. This was an injustice to Mr A. The Ombudsman welcomed the measures the Health Board had introduced as a result of the complaint.

The Ombudsman recommended that the Health Board provide a fulsome apology to Mr and Mrs A for the clinical and administrative failings identified by the investigation. The Health Board was also asked to ensure that a system was put in place so that urgent communication from GP is seen and actioned within an agreed time frame.

[A Medical Practice in the area of Powys University Health Board - Clinical treatment outside hospital](#)

[Case Number: 201807254 – Report issued in January 2020](#)

Mr A complained about the care and management his wife, Mrs A, received from the medical and nursing staff at a GP Practice in January 2019. Mr A said that his wife complained of blood in her urine and despite having a previous history of bladder cancer her care was not immediately referred to a GP by the nursing staff. Mr A also expressed concerns about the robustness of the Practice's complaint response.

The Ombudsman's investigation concluded that Mrs A's initial management by the Locum GP was reasonable and appropriate. However, he had concerns about Mrs A's management from 18 January onwards, when she contacted the GP Practice as her symptoms had not improved. The Ombudsman was of the view that the Triage Nurse should have arranged for Mrs A to see a GP to have further urine tests carried out to rule out a urinary tract infection ("UTI"). This would have helped the GP to identify that Mrs A did not have a UTI, but a kidney problem. As a result, her outpatient appointment could have been expedited and Mrs A's subsequent emergency hospital admission might have been avoided. This, and the fact that Mrs A had to repeatedly contact the Practice due to her ongoing symptoms, was an injustice to her. It was to that extent only that the Ombudsman upheld this aspect of Mr A's complaint.

In relation to Mr A's expressed concerns about the robustness of the Practice's complaint response, the Ombudsman's investigation found that the response was timely and appropriately identified areas for learning and improvement. This aspect of Mr A's complaint was not upheld. The Ombudsman recommended that the GP Practice apologise to Mr and Mrs A for the shortcomings in Mrs A's care. In addition, the GP Practice was asked to remind its telephone triage staff of the national guidance on the management of UTIs.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201801893 – Report issued in January 2020

Mrs A complained about the care and treatment provided to her 2-year-old son by the Health Board. She said that the out of hours GP (“OOH GP”) failed to carry out relevant examination and sent him home with antibiotics. Mrs A also complained about the subsequent care her son received at Royal Glamorgan Hospital’s (“the Hospital”) Emergency Department (“ED”) including a failure to diagnose sepsis. Mrs A also complained about the Health Board’s complaint handling.

The Ombudsman’s investigation concluded that the care Mrs A’s son received in the ED was reasonable and appropriate. In relation to Mrs A’s complaint about the Health Board’s handling of her complaint, the Ombudsman found that whilst there was delay in responding to her complaint, the delay was not unreasonable. He was, however, concerned about the way in which it handled the response regarding the clinical care provided by an OOH GP. By the time the Health Board had written to Mrs A, it had already referred the OOH GP to the General Medical Council. This information had not been relayed to Mrs A and, as a result, the Health Board’s complaint response was inaccurate and misleading. This aspect of Mrs A’s complaint was therefore upheld.

The Health Board was asked to apologise to Mrs A for the shortcomings in its complaint handling and communication with her. The Health Board was asked to put in place measures to ensure that where a clinician is subject to a complaint and has been referred to the GMC this is highlighted to the concerns team and, where relevant, the Ombudsman.

Abertawe Bro Morgannwg University Health Board - Clinical treatment outside hospital

Case Number: 201806225 – Report issued in January 2020

Mr O complained about the overall treatment and care of his mother, Mrs P, by staff at the Princess of Wales Hospital from 30 September 2018 up until her sad death on 22 October. In particular, Mr O was unhappy about the monitoring of Mrs P’s food intake and nutritional reviews, poor communication by staff and the lack of dignity in Mrs P’s last days.

The Ombudsman found that the monitoring of Mrs P’s food intake and nutritional reviews were inadequate; staff did not follow the Health Board’s own assessment criteria, and national guidelines, resulting in them being unable to determine whether Mrs P had an adequate dietary intake. The Ombudsman also found that there was a missed opportunity to determine whether Mrs P required the specialist input of a Dietician. The Ombudsman concluded that these service failures had a detrimental effect on Mrs P’s overall condition.

The Ombudsman also found that there was poor communication between Mrs P’s family and staff, with very few entries detailing family visits and discussions about Mrs P’s condition. In addition, the Ombudsman concluded that discussions surrounding Mrs P’s dignity in her last days did not appear to begin until 24 hours prior to her death and were prompted by the family.

The Ombudsman upheld Mr O’s complaint and recommended that the Health Board apologised and made financial redress payment of £1,000. The Ombudsman also recommended that his report was shared with staff involved with Mrs P’s care and that the Health Board ensured staff had undergone professional standards training. The Health Board agreed to the Ombudsman’s recommendations.

A GP surgery in the area of Abertawe Bro Morgannwg University Health Board - Patient list issues

Case Number: 201803704 – Report issued in January 2020

Ms A complained about a GP surgery (“the First Surgery”) in the area of Abertawe Bro Morgannwg University Health Board (“the Health Board”). She said that the First Surgery’s decisions to remove her name from its patient list and not to retain it on that list in response to her request had been unreasonable. She also reported that the First Surgery had passed factually incorrect and inappropriate

information about her to another GP surgery ("the Second Surgery"). She indicated that she had a mental health disability and referred to the Equality Act 2010 ("the Act").

The Ombudsman could not determine that the First Surgery's decision to remove Ms A's name from its patient list had been unreasonable. However, he found that the First Surgery had not explained that decision to Ms A clearly. He partly upheld the removal aspect of Ms A's complaint. He determined that the First Surgery had not shown that it took its decision not to retain Ms A's name on its patient list properly. He considered that Ms A's explicit request for a reasonable adjustment, in terms of her patient list position, had been sufficient to engage the Act. He partly upheld the retention element of Ms A's complaint. He could not establish that the First Surgery had given the Second Surgery erroneous and improper information about Ms A. He did not uphold the disclosure part of Ms A's complaint.

The Ombudsman recommended that the First Surgery should apologise to Ms A. He also asked it to consider introducing a reasonable adjustment policy. The First Surgery agreed to implement these recommendations.

[A GP surgery in the area of Abertawe Bro Morgannwg University Health Board – Other](#) [Case Number: 201803703 – Report issued in January 2020](#)

Ms A complained about a GP surgery ("the Surgery") in the area of Abertawe Bro Morgannwg University Health Board ("the Health Board"). She said that the Surgery's request for her to sign an Acceptable Behaviour Contract ("the ABC") had been unreasonable. She stated that the Surgery had not given her reasonable access to a GP. She also reported that she was dissatisfied because the Surgery had taken too long to respond to her complaints about these issues. She indicated that she had a mental health disability and referred to the Equality Act 2010 ("the Act").

The Ombudsman found that the Surgery's use of the ABC had been inappropriate and that its management of the related signing process had been inadequate. He considered that Ms A's concerns about the Surgery's use of the ABC had been sufficient to engage the Act. He upheld the ABC-related part of Ms A's complaint. He was satisfied that the Surgery had given Ms A reasonable access to a GP and did not uphold this aspect of her complaint. He found that the Surgery had not explained why its response to Ms A's complaint had been delayed. He partly upheld the complaint handling element of Ms A's complaint.

The Ombudsman recommended that the relevant GPs ("the GPs") should apologise to Ms A and pay her £250. The GPs agreed to provide the apology recommended. The Health Board agreed to implement the financial redress recommendation.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201803702 – Report issued in January 2020](#)

Ms A's complaint about the former Abertawe Bro Morgannwg University Health Board concerned its GP Out of Hours Service ("the OOH Service"), its response to her concerns about 2 GP surgeries ("the Surgeries") and its complaint handling. She complained that OOH Service staff had not adhered to Chaperoning Guidelines ("the Guidelines"). She indicated that she was dissatisfied because the Health Board had allowed the Surgeries to investigate her concerns about their own actions and had not intervened in response to one of those concerns. She complained that the Health Board had taken too long to address her complaint about the OOH Service. She indicated that she had a mental health disability and referred to the Equality Act 2010 ("the Act").

The Health Board indicated that its OOH Service staff had breached the Guidelines. The Ombudsman accepted this and upheld the OOH Service part of Ms A's complaint. He found that the Health Board had not demonstrated that it had taken its decisions, about how to respond to Ms A's concerns about the Surgeries, properly. He also determined that it had not fully complied with the relevant complaint handling regulations when responding to Ms A's concerns about one of those Surgeries. He considered that Ms A's concerns about the Surgeries and the circumstances surrounding those concerns had been sufficient to

engage the Act. He partly upheld that aspect of Ms A's complaint which concerned the Health Board's responses to her concerns about the Surgeries. He found that the Health Board's handling of Ms A's complaint about the OOH Service, after it had issued its initial written response, was compromised by a delay and a communication deficiency. He partly upheld the complaint handling element of Ms A's complaint as a result.

The Ombudsman recommended that the Health Board should apologise to Ms A and that it should pay her £750. He asked it to send her chaperone-related information. He recommended that it should clarify the nature of the reasonable adjustments sought by Ms A and that it should outline its position regarding them. He asked it to prepare guidance for its complaint handling staff about the management of complaints, which addresses the failings identified and the requirements of the Act.

The Health Board agreed to implement these recommendations.

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

[Case Number: 201807057 – Report issued in January 2020](#)

In 2015 Cwm Taf University Health Board ("the First Health Board") referred Mr X to Cardiff and Vale University Health Board ("the Second Health Board") for treatment for the degenerative disease in his neck and spine and the associated pain he experienced. Mr X complained that there had been a delay in treating his symptoms. Mr X also complained about the Second Health Board's response to his complaint.

The investigation found that the Second Health Board had already recognised and apologised for the delays Mr X had experienced in his treatment pathway as a result of administrative errors. The investigation also noted that, had Mr X not been referred for a second opinion, further delays may have been caused by the failure to request up to date scans. The investigation found that, whilst an incremental approach to Mr X's treatment was appropriate, the reasons for this approach were not fully explained to Mr X. Further, his expectations of the referral for a second opinion were not properly managed.

The complaint was upheld in part. It was recommended that the Second Health Board apologise to Mr X for the failings identified, and that the relevant clinicians consider this report so that any lessons were identified and shared within the relevant departments.

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

[Case Number: 201802486 – Report issued in January 2020](#)

Mr A complained about the care and treatment provided by the Health Board to his 94 year old mother Mrs B, following her admission to hospital. Mr A complained about delays in Mrs B being transferred to the Acute Stroke Unit and a lack of consciousness and capacity assessments. Mr A also complained about inadequate falls risk assessments, the inappropriate use of a cardiac monitor, a failure to address personal care needs, communication following a fall and a delay in diagnosing a fractured pelvis. Mr A also complained that the Health Board failed to adequately manage his complaint.

The Ombudsman found that the timing of Mrs B's transfer was reasonable, that her level of consciousness was assessed and that a capacity assessment would not have been appropriate. The Ombudsman found no evidence of unreasonable delay in diagnosing the fractured pelvis nor that personal care needs had been neglected. He did not uphold these aspects of the complaint.

The Ombudsman found shortcomings in the records regarding the use of the cardiac monitor, along with insufficient management of Mrs B's risk of falls and inadequate communication following her fall. The Ombudsman found failings in the Health Board's management of Mr A's complaint, including a lack of clarity and avoidable delays. The Ombudsman therefore upheld these aspects of the complaint.

The Health Board agreed it would apologise to Mr A for the failings identified. It agreed to share the

report with relevant nursing and complaints handling staff, to provide additional training in respect of the failings identified and to make a payment of £250 to Mr A in recognition of the inadequate complaint handling. Finally, using the NHS redress arrangements and based upon the failings identified, the Health Board agreed to consider what redress is appropriate and to make a payment to Mrs B of the identified redress amount.

[Powys Teaching Health Board & Aneurin Bevan University Health Board - Clinical treatment in hospital](#) Case Number: 201807414 & 201808015 - Report issued in February 2020

Powys Teaching Local Health Board ("the First Health Board") has commissioned Aneurin Bevan University Health Board ("the Second Health Board") to provide healthcare to its residents living in a specified geographical area.

Mrs A complained about her late husband's management and care, including his cancer care. Sadly, Mr A died shortly after being diagnosed with advanced cancer. Mrs A was also dissatisfied with the First Health Board's handling of her complaint. The Ombudsman's investigation found that Mr A had been appropriately diagnosed with inflammatory bowel disease/colitis following a colonoscopy in 2016. The Ombudsman therefore did not uphold this part of Mrs A's complaint in relation to the First Health Board.

In terms of the Second Health Board the Ombudsman found that broadly Mr A's inpatient management and care in 2017 was reasonable and appropriate. However, he did identify failings around the Second Health Board's management of Mr A's malignant abdominal ascites (an abnormal build-up of malignant cancer fluid in the abdominal cavity). In upholding these aspects of Mrs A's complaint, the Ombudsman concluded that the failings had caused Mr A and his family an injustice, given the additional discomfort and pain Mr A suffered, and the fact that he had contracted an infection and developed sepsis (due to the prolonged use of a temporary ascites drain) which had impacted adversely on the quality of his end of life experience. The Ombudsman also found that communication was not as effective as it could have been, which was not helped by poor documentation. He considered that the communication failings caused Mr A and his family an injustice given its impact again on Mr A and his family's end of life experience.

The Ombudsman found that the GP Practice's management of Mr A's diabetes was appropriate and reasonable. He did not find any evidence that the GP Practice could have done more to have ruled out cancer at an earlier stage. These parts of Mrs A's complaint were not upheld.

The Ombudsman found failings in aspects of the First Health Board's handling of Mrs A's complaint which meant that the response provided was not as robust as it could have been. This and administrative delays in providing the response, had caused Mrs A additional distress as she had to pursue her complaint further in order to obtain answers. This represented an injustice for Mrs A.

The Ombudsman made wide ranging recommendations including that both Health Boards apologise for the failings identified. Clinically, the Second Health Board was also asked to develop a clear policy for ascitic drain insertion and management and, in terms of pain management, it should implement medication dose increases made via the syringe driver on the same day. In addition, nursing staff were to be reminded of the need to document the effectiveness of pain relief given to patients. The recommendations also included clinical learning from Mrs A's complaint. Given the failings identified the Second Health Board also agreed to consider Mrs A's case at its Redress Panel.

The First Health Board, as well as learning lessons concerning complaint handling, also agreed to make a payment to Mrs A of £250.00 for the failings identified.

[Cwm Taf University Health Board - Clinical treatment in hospital](#) Case Number: 201806054- Report issued in February 2020

Mrs A complained about the treatment and care provided by the ("Health Board") for her late father, Mr B, at the Royal Glamorgan Hospital ("the Hospital") following a fall at home. Mrs A said the Health Board

failed to diagnose Mr B's life-threatening haemothorax (a collection of blood in the space between the chest wall and the lung), gave misleading information to the family about his condition, and failed to provide him with an appropriate level of care because of assumptions made about the quality of his life. Mrs A also complained about the Health Board's handling of her complaint.

The Ombudsman found that, although there was delay before Mr B's haemothorax was diagnosed, it would not have altered his management which was appropriate. However, there was a failure to fully involve the family in informed decision making around Mr B's care which was important because Mr B was not able to express his own views and wishes. The Health Board had already taken appropriate action to remedy the communication failings in this case. Although the Health Board agreed with Mrs A that it would arrange for an independent review of Mr B's care, it failed to share the findings of that review in full. Contrary to that agreement, the Health Board also sought comments from a senior clinician directly involved with Mr B's care, causing delay and undermining the independence of the review. Finally, the Health Board failed to respond to Mrs A's second letter of complaint, leaving aspects of the complaint unresolved.

The Ombudsman recommended that the Health Board apologise to Mrs A for the failings identified and pay her £250 in recognition of the poor handling of her complaint. The Health Board also agreed to share the full findings of the independent review with Mrs A.

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

[Case Number: 201805797 - Report issued in February 2020](#)

Ms B complained that she was forced to push too early during her labour, causing foetal distress (where the baby does not receive enough oxygen). Ms B also complained about the accuracy of Cwm Taf University Health Board's ("the Health Board's") written response to her complaint which had been posted to the wrong address. Ms B said that the response contradicted her recollection of events and what the Health Board had said at meetings to discuss her complaint.

The Ombudsman did not find any evidence to suggest that early pushing by Ms B had a detrimental impact on her baby. However, contrary to professional standards of practice, there were insufficient records to support the account of Ms B's care that the Health Board had given. The Health Board also failed to keep accurate records of two meetings with Ms B to discuss her complaint. The Ombudsman concluded that the record keeping failings in this case contributed to Ms B's doubts about her care, her lack of confidence in the Health Board's complaint investigation, and to the complaint response being sent to the wrong address, causing injustice to Ms B.

The Ombudsman recommended that the Health Board pay £250 to Ms B for the failings identified, and that it reminds the staff who met with Ms B of the record keeping requirements when handling complaints.

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

[Case Number: 201806908 - Report issued in February 2020](#)

Mr Q complained that when he underwent knee surgery in October 2016, the First Surgeon did not familiarise himself with Mr Q's notes and medical history. Mr Q said this resulted in the wrong knee replacement joint being used and a longer than necessary period of recuperation. Mr Q said that he sought a second opinion from a Second Surgeon who supported his views. Mr Q has since had a second, successful, operation.

The Ombudsman's investigation found that whilst the First Surgeon might not have fully familiarised himself with Mr Q's previous medical history, based on Mr Q's presentation at the time, the knee replacement joint that was used was the correct one. The Ombudsman noted, however, that alternative surgical options should have been available during the surgery as Mr Q's medial collateral ligament (MCL) laxity (looseness) was found to be significant. The Ombudsman concluded that this was not appropriately

dealt with and contributed to Mr Q's longer than necessary recuperation.

The Ombudsman also found that Mr Q was not informed about a change in surgeon until the day of his procedure. The Ombudsman said this was unacceptable and not in keeping with relevant guidance regarding "pooled patients" (when patients are moved from one consultant to another to minimise waiting times and balance workloads).

The Ombudsman did not uphold Mr Q's complaint about the wrong knee replacement joint being used. However, the Ombudsman did uphold Mr Q's complaint about the length of his recuperation and for not being informed about a change in surgeon in a timely manner.

The Ombudsman recommended that the Health Board apologised to Mr Q and makes a payment of £650 to reflect the injustice he had suffered. The Ombudsman also recommended that his report was shared with the First Surgeon and the Health Board's orthopaedic team. Finally, he recommended that the Health Board review its pooled patients waiting lists to ensure they reflected best practice and were patient focused.

The Health Board agreed to implement the Ombudsman's recommendations.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201806835 - Report issued in February 2020

Mrs D complained about the care and treatment that her late mother, Mrs M, received at Llandough Hospital following her admission on 12 February 2018 (with a history of vomiting, weight loss and acute dehydration) until her death from bronchopneumonia on 28 February 2018. Mrs D complained that:

- a) There were failings and delays in the diagnosis and treatment of Mrs M's kidney condition and her conditions of heart failure, atrial fibrillation and abdominal pain were not adequately investigated and treated.
- b) Clinicians were slow to recognise that Mrs M's medication had caused/aggravated her kidney injury. This delay hastened her deterioration.
- c) Clinicians failed to appropriately respond to the family's concern that Mrs M had deteriorated and failed to promptly identify and treat her condition of bronchopneumonia.
- d) The Health Board misplaced Mrs M's medical records after her death. Though eventually located, this delayed its investigation of the complaint. Mrs M's death certificate inaccurately listed Chronic Kidney Disease (CKD) as a cause of death.

The Ombudsman did not uphold complaints 1 and 2 as he determined that Mrs M's medical care and medication management were appropriate, but upheld complaints 3 and 4. With regard to complaint 3, the Ombudsman found that although clinicians did respond promptly to Mrs M's condition of bronchopneumonia, there was a communication breakdown in the response of a junior doctor to the family's concerns about Mrs M's deterioration. With regard to complaint 4, the Ombudsman found that the family was not informed that Mrs M's medical records could not be located. Though subsequently found, the inconvenience this gave rise to was an injustice to the family. The Ombudsman found that the Health Board amended the secondary cause of death (as stated on the death certificate) at the request of the family and so did not uphold this aspect of the complaint.

The Ombudsman recommended that the Health Board provide Mrs D with a written apology for the identified communication failing and for the failings surrounding the loss of records. He recommended that the Health Board offers Mrs D £250 in recognition of the time and trouble to which she was put as a result of the loss of records.

The Ombudsman recommended that the Health Board provide evidence that the Junior Doctor referred to in the report has reflected on the identified shortcomings and on the need to apply caution to how prognoses are formulated and conveyed to patients and relatives. He further recommended that the Health Board provides an account of measures taken to ensure the safe management and security of medical records and that the report is shared with the Concerns Team (with a reminder that complainants are informed of any loss of records and consideration given as to whether such loss should be reported to the ICO).

The Health Board agreed to implement these recommendations.

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

[Case Number: 201805960 - Report issued in February 2020](#)

The Ombudsman recommended that the Health Board provides Mrs M with a fulsome written apology for the clinical and care-management failings identified in the investigation and, in recognition of the avoidable distress, disruption and anxiety that she experienced as a result, makes a payment to her of £500.

The Ombudsman further recommended that the Health Board provides his office with evidence that this report has been shared and discussed with the midwives and obstetric physicians at RGH who provided Mrs M's care and provides details of additional training in post-partum bladder care they have undergone. Finally, the Ombudsman recommended that senior obstetric physicians at RGH are reminded of the importance of:

- a) Identifying and flagging risk factors in antenatal notes.
- b) Devising and recording appropriate care-management plans for women at risk of urinary retention in the post-partum period.
- c) Accurately maintaining frequency volume charts; assessing and managing post-void residuals and conducting bladder scans in accordance with clinical guidelines.

The Health Board accepted and agreed to implement these recommendations.

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

[Case Number: 201806766 - Report issued in February 2020](#)

Mrs A complained about the Princess of Wales Hospital's ("the Hospital") care and management of her late mother's Barrett's oesophagus diagnosis. She was concerned that the condition might have contributed to her mother's severe reaction when she had osteoporosis treatment. Mrs A expressed concerns about a breakdown of communication with the family and her mother, Mrs C, during her mother's last inpatient admission. Finally, Mrs A complained about the adequacy of the Health Board's complaint response.

The Ombudsman's investigation concluded that clinically the Health Board's management of Mrs C's Barrett's oesophagus was appropriate and that it had been taken into account during Mrs C's osteoporosis treatment. In relation to Mrs C's inpatient admission, the Ombudsman recognised that the family were understandably distressed that their mother had died on the ward. However, he noted that there was a lack of bed spaces at the specialist palliative care unit and that isolating patients with influenza meant cubicles were not available. From a palliative care perspective, the Ombudsman did not feel that more could have been done. He did not uphold these parts of Mrs A's complaint.

The Ombudsman identified communication shortcomings which were not helped by inadequate record-keeping. Additionally, the Health Board's complaint handling was insufficiently robust. The Ombudsman concluded that the distress these failings had caused represented an injustice to Mrs A and the family. He

upheld these parts of Mrs A's complaint.

The Ombudsman recommended that the Health Board should apologise to Mrs A for the communication and complaint handling failings and, as requested by Mrs A, it should pay to her named charity the £250 complaints handling redress payment it had offered. The Health Board was also asked to consider providing its clinicians with communication training.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201903243 - Report issued in February 2020](#)

On 19 June 2019, Mrs X was admitted under section 2 of the Mental Health Act 1983 (detained at a hospital for 28 days for assessment). Mrs X complained about the Cardiff and Vale University Health Board's bed allocation between 30 June and 3 July, her restraint and forcible injection on 2 July, the reintroduction of medication and whether she was treated differently because she is "black".

The Ombudsman upheld the complaint that on 2 July, in view of Mrs X's poor presentation her suitability to sleep away from the ward should have been considered before 20:14. The Ombudsman found that Mrs X's restraint and injection were reasonable as was the reintroduction of her medication. The Ombudsman also found that there was no substantive evidence that Mrs X was treated differently because of her race.

The Health Board agreed to implement the Ombudsman's recommendations and apologise to Mrs X for the 2 July failing and to remind the staff of the importance of identifying suitable patients to sleep out earlier and ensure those conversations are documented.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201804295 - Report issued in February 2020](#)

Mrs D complained about Aneurin Bevan University Health Board's overall communication with her late father, Mr T, and its care and treatment of him between July 2017 and March 2018. In particular, Mrs D was unhappy that the Health Board failed to: arrange a CT scan following Mr T's appointment with a cardiology specialist, failed to diagnose Mr T with pulmonary hypertension sooner, failed to communicate with Mr T in relation to his enlarged lymph nodes, discharged Mr T in February 2018 when he was not fit for discharge, failed to take appropriate action when Mr T developed a stage 2 pressure ulcer and failed to recognise Mr T's deteriorating renal functions sooner and take appropriate action.

The Ombudsman's investigation found that the care and treatment of Mr T was, overall, appropriate during this time period and the Ombudsman did not uphold 5 of the 6 complaint elements. However, the Ombudsman did uphold Mrs D's complaint about the failure to take timely action in relation to Mr T's stage 2 pressure sore. The Ombudsman determined that the pressure sore could have been avoided had an appropriate risk assessment been carried out.

The Ombudsman also highlighted a couple of examples of poor communication and poor standards in clinical documentation. Some letters were not copied to Mr T so he was left in the dark for a short time as to what staff were doing in terms of his treatment and an inappropriate note was made by a urology doctor in Mr T's records when there was confusion over who was overseeing his care.

The Ombudsman recommended that the Health Board apologise to Mrs D for the failings identified and share its results of its root cause analysis into Mr T's pressure sore. He also recommended that the report was shared with staff involved with Mr T's care, so they could be reminded of their duties in relation to effective communication, teamwork and record keeping standards.

Although not a formal recommendation, the Ombudsman invited the Health Board to consider ensuring all its letters are in future copied to the patient as well.

The Health Board agreed to the Ombudsman's recommendations.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201800202 - Report issued in February 2020

Mrs A said that following the birth of her child in 2015, she was diagnosed with a triple pelvic prolapse (when the network of supporting tissues holding the bladder, bowel and womb becomes weakened and these organs drop, or bulge into the vagina) and coccydynia (pain in the last bone of the bottom of the spine - the coccyx). Mrs A complained that Aneurin Bevan University Health Board:

- failed to provide her with co-ordinated treatment from the Gynaecology, Colorectal, Urology and Orthopaedic departments
- failed to treat her within a clinically appropriate timescale.

The Ombudsman found that whilst the care and treatment provided by the Health Board was broadly appropriate and carried out in a timely manner, there were some service failings which caused Mrs A an injustice. These related to significant delays in carrying out anorectal investigations as the necessary equipment was broken, the fact an MRI scan had to be repeated due to the original not including the correct area, and poor records of multidisciplinary team (MDT) discussions. The Ombudsman partly upheld Mrs A's complaints to the extent of the service failings identified.

The Ombudsman recommended that the Health Board provide Mrs A with a written apology. He also recommended that the Health Board should examine why the MRI scan did not cover the required area, remind its urology, urogynaecology and colorectal clinicians of the need to ensure that MDT discussions and any resulting treatment plans are adequately recorded in the clinical notes, and review its contingency plans for the provision of anorectal investigations in the event the equipment is unavailable. The Ombudsman also recommended that the Health Board should review its treatment pathways and referral patterns as part of the MDT approach to treating pelvic floor dysfunction. As part of this, he noted that the Health Board might wish to consider whether there is merit in holding joint pelvic floor clinics with urology, urogynaecology and colorectal input.

Betsi Cadwaladr University Health Board - Other

Case Number: 201803743 - Report issued in February 2020

Mr A complained about the care given to his late wife, Mrs A, by Betsi Cadwaladr University Health Board ("the Health Board"). He said that the Health Board had taken too long to formally diagnose Mrs A's advanced bowel cancer. He stated that the Health Board had failed to access additional nursing support for Mrs A on the night that she died. He reported that the Health Board had not assisted him with an Attendance Allowance application despite indicating that it would do so.

The Ombudsman found that the Health Board had taken too long to give Mrs A her cancer diagnosis. He partly upheld the clinical care aspect of Mr A's complaint. He noted that the Health Board had not ensured that Mr A had received a satisfactory response to a telephone call, which had been made to a potential source of nursing support, on the night that Mrs A died. He partly upheld the nursing support element of Mr A's complaint. He found that the Health Board had indicated that it would help Mr and/or Mrs A to apply for Attendance Allowance and that it had then failed to do this. He upheld the welfare benefit part of Mr A's complaint.

He recommended that the Health Board should apologise to Mr A for the failings identified. He asked it to consider preparing an information leaflet, about community support services, for terminally ill patients and their carers. He recommended that it should take steps to introduce a system for reminding referring clinicians to check that they have received diagnostic results, if it determines that such a system would be feasible. He asked it to implement an action plan to reduce the likelihood of diagnostic results being missed by clinicians, if it determines that a clinician reminder system is not feasible. He also recommended that it should take action to ensure that effective arrangements for acting on diagnostic

results, when the referring clinicians are absent, are in place. The Health Board agreed to implement these recommendations.

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

[Case Number: 201900630 - Report issued in March 2020](#)

Mrs A complained about the care and treatment her husband, Mr A, received from Aneurin Bevan University Health Board ("the Health Board"). Mrs A's concerns were that Mr A was over-medicated whilst in hospital, causing severe side effects, including an injury to his neck and an overall deterioration in his condition. Mrs A's concerns also included the nursing care provided to her husband whilst he was in hospital and the Health Board's handling of her complaint.

The Ombudsman's investigation concluded that the care and treatment provided to Mr A by the Health Board, in terms of both medication and nursing care, were reasonable and appropriate. Whilst noting that Mr A's condition deteriorated, this could not reasonably be attributed to the care or treatment provided. However, the investigation identified some administrative shortcomings in the way in which Mrs A's concerns were managed by the Health Board. The Ombudsman concluded that the Health Board's complaint handling had been protracted and excessive, causing injustice to Mrs A.

The Health Board agreed to recommendations to apologise to Mrs A and make a time and trouble payment to her of £500.

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

[Case Number: 201902238 - Report issued in March 2020](#)

Mrs H complained about the care and treatment provided by Hywel Dda University Health Board ("the Health Board") to her late husband Mr H between December 2017 and August 2018, concerning respiratory (breathing system), oncology (cancer) and nursing care.

The Ombudsman found there were two occasions when Mr H's calls to the oncology triage line were not dealt with correctly; however, he was provided with correct advice and appropriate care and treatment, following subsequent calls to the triage line, and there was no impact on his clinical course or outcome. The Ombudsman also found that Mr H's overall care and treatment was reasonable and consistent with acceptable practice, therefore these elements of the complaint were not upheld. The Ombudsman found there was a failure in communication with Mr H and his family concerning his expected outcomes which caused anxiety and distress, and this aspect of the complaint was upheld.

The Health Board agreed within 1 month to apologise to Mrs H for the failings identified. It also agreed to review communication practices regarding patient outcomes and options for end of life care, to identify any relevant training needs and to share the report with relevant staff for critical reflection.

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

[Case Number: 201900506 - Report issued in March 2020](#)

Mr A complained about his care and treatment by Cardiff and Vale University Health Board ("the Health Board") when he attended its Emergency Department ("the ED") following an accident and injury to his ankle. X-rays were taken identifying a fracture and a query about the existence of a talar shift (widening of the space between the two ankle bones). Mr A was placed in a cast, discharged home with a walking frame and told to attend a fracture clinic for review (at another hospital closer to Mr A's home) in a week's time. At the clinic, Mr A said that his records from the ED were not available for the clinician and so other X-rays were taken. A talar shift was confirmed and Mr A was told he required surgery. Mr A complained that the ED had failed to correctly manage him and that he ought to have been admitted for surgery at the time. He said it had failed in any event to provide him with appropriate mobilisation advice or inform him of the possibility of surgery, meaning that he had to cancel a pre-planned holiday as he was unable to fly.

The investigation found that Mr A's clinical management by discharging him with a below the knee plaster cast and a fracture clinic appointment was appropriate. The first X-ray was not conclusive in relation to the talar shift and repeat X-rays would always be undertaken at the fracture clinic review. Whilst it was uncertain whether the ED clinician was aware of Mr A's holiday plans, there was no injustice to him as the surgery meant he was unable to fly anyway and had to cancel. These complaints were not upheld. Whilst acknowledging that the ED had no crutches to provide Mr A on discharge, meaning that the walking frame was not ideal, there was no proper documentary evidence of undertaking a mobility assessment in Mr A's records. The Ombudsman upheld the complaint about a lack of mobilisation advice.

The Health Board agreed to implement the following recommendations made by the Ombudsman, within one month:

- a) To apologise to Mr A
- b) To remind staff of the importance of completing appropriate mobility assessments, documenting them, and providing patients with mobility advice when providing walking aids.

[A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital](#)
Case Number: 201807090 - Report issued in March 2020

Mrs X complained about two consultations at a GP Practice ("the Practice") that her daughter (Miss Y, aged 14) had attended. Both consultations were with the same locum GP ("the GP") in June and July 2018. Miss Y had presented with symptoms of acne, hair loss, feeling faint and heavy blood loss during her periods. Mrs X complained that at the first consultation the GP had inappropriately discussed Miss Y's diet with her and not calculated her BMI correctly (by using an adult chart as opposed to a paediatric version). Miss Y's blood was taken for testing. At the July consultation (to discuss the blood results), Mrs X said that the GP performed an intimate examination of Miss Y, using a speculum (an instrument used to dilate a body cavity to allow for a better inspection), without sufficient explanation and without either Miss Y or Mrs X's consent. The examination caused her daughter pain and Mrs X said she had not been sufficiently covered to maintain her dignity. Mrs X also complained about the delay in responding to her formal complaint.

The GP herself had written the complaint response to Mrs X, when the Practice should have responded on behalf of a locum. Mrs X waited over 4 months for the response to her complaint. In examining the clinical records during the investigation, it was established that the GP had retrospectively included an additional entry about each consultation, denoting that an explanation was given in July for the examination and that consent had been obtained. The entries were written 1 month after Mrs X had formally complained to the Practice (a month and 2 months respectively after the consultations). The Ombudsman concluded that there was service failure in that the consultations were not of the appropriate standard. In particular he found that:

- a) there was an inadequate written record of the consultations at the time particularly regarding consent
- b) later entries appeared prompted by receiving the complaint and so they did not fully corroborate the GP's recollection
- c) professional guidance suggested Miss Y ought to have been allowed thinking time to consider the examination before returning to undertake it at a later date (iv) the GP agreed that she had forgotten to cover Miss Y sufficiently to maintain her dignity and that Miss Y should have been offered a chaperone for the examination. He upheld the complaints.

The Ombudsman recommended that:

- a) the Practice apologise in writing to Mrs X and Miss Y

- b) the case should be discussed at the next Practice meeting as a means of reflecting and learning and
- c) the GP should further reflect on matters and provide evidence of discussion about the case with her GP appraiser.

Not Upheld

Aneurin Bevan University Health Board - Clinical treatment outside hospital

Case Number: 201807270 & 201806337 – Report issued in January 2020

Miss X was concerned that there had been an unreasonable delay in taking action in respect of, and diagnosing, her son's ("A") condition of Type 1 Spinal Muscular Atrophy (SMA is a rare genetic condition which causes progressive muscle weakness due to muscle wasting – Type 1 develops in babies less than 6 months old and is the most severe type of this genetic disease). She considered that had it been diagnosed sooner, the appropriate treatment could have been provided sooner which would have benefited him much more and possibly prolonged his life significantly, by months or years. Miss X was aggrieved that GPs at the Practice and the Health Visiting Service ignored her concerns about her son's development and problems and her requests for assistance.

The investigation found that the care provided to A had broadly been appropriate and Miss X's concerns about A's development had not been inappropriately ignored by the healthcare professionals involved in his care. The complaint was, therefore, **not upheld**.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201902069 – Report issued in January 2020

Miss X complained about her assessment and treatment by the Physiotherapy Service, that she was unfairly discharged from their service, and that their records were biased, inaccurate and derogatory. Miss X also complained that the response provided by the Health Board did not fully address her concerns.

The investigation found that:

- The assessment and treatment by the Physiotherapy Service was reasonable and it was appropriate to discharge Miss X from the Physiotherapy Service.
- There was no evidence of derogatory comments in the physiotherapy notes.
- The Health Board adequately addressed Miss X's concerns.

Therefore, Miss X's complaints were not upheld.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201807058 – Report issued in January 2020

In 2015 Cwm Taf University Health Board ("the First Health Board") referred Mr X to Cardiff and Vale University Health Board ("the Second Health Board") for treatment for the degenerative disease in his neck and spine and the associated pain he experienced. Mr X complained that there had been a delay in treating his symptoms. Mr X also complained about the Second Health Board's response to his complaint.

The investigation found that the Health Board had already recognised and apologised for the delays Mr X had experienced in his treatment pathway as a result of administrative errors. The investigation also noted that, had Mr X not been referred for a second opinion, further delays may have been caused by the failure to request up to date scans. The investigation found that, whilst an incremental approach to Mr X's treatment was appropriate, the reasons for this approach were not fully explained to Mr X. Further, his expectations of the referral for a second opinion were not properly managed.

The complaint was upheld in part. It was recommended that the Second Health Board apologise to Mr X for the failings identified, and that the relevant clinicians consider this report so that any lessons were identified and shared within the relevant departments.

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

[Case Number: 201805385 & 201805384 – Report issued in February 2020](#)

Mrs X complained that Aneurin Bevan University Health Board failed to undertake appropriate and timely investigations into her symptoms, which led to a delay in her diagnosis of Hodgkin's Lymphoma (a type of cancer that develops in the lymphatic system, which is a network of vessels and glands spread throughout the body). She also complained that Cardiff and Vale University Health Board damaged and briefly lost a biopsy sample which meant Mrs X had to undergo a more invasive operation and led to a further delay in her diagnosis.

The Ombudsman found that investigations into Mrs X's symptoms by Aneurin Bevan University Health Board were undertaken in a timely manner and were appropriately thorough. It found no evidence to suggest that a biopsy sample had been lost. There was evidence to show that the biopsy sample was appropriately processed within Cardiff and Vale University Health Board's target time of 30 working days. The Ombudsman found that an issue with the structure of the cells in the biopsy sample caused it to be difficult to interpret, which led to a need for Mrs X to undergo a further and more invasive procedure. However, there was no evidence to suggest that the sample had been damaged or mishandled by Cardiff and Vale University Health Board.

The complaints were not upheld.

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

[Case Number: 201900580 – Report issued in February 2020](#)

Mr A complained about the care and treatment his wife received at a GP Practice ("the Practice"). On 10 April 2018 Mr A's late wife attended a consultation with one of the GPs ("the GP") as she was experiencing breathlessness when walking. Mr A said that there was a missed opportunity to diagnose and treat his wife in a timely manner. Mr A also complained about the Practice's handling of his complaint.

The Ombudsman's investigation identified shortcomings in the care Mrs A received from the GP which included poor clinical assessment of Mrs A's presenting symptoms and her pre-existing conditions. The Ombudsman concluded that whilst the shortcomings did not accord with national guidance and failed to explore other potential causes of Mrs A's symptoms, Mrs A was appropriately referred for further tests and that the subsequent test results did not show any significant signs that warranted a change in Mrs A's management or a referral to hospital. Although the GP's shortcomings did not cause Mrs A an injustice and the Ombudsman did not uphold this aspect of Mr A's complaint, the Ombudsman did invite the GP to reflect upon this case as part of wider learning.

Finally, the Ombudsman concluded that the GP Practice's complaint handling and communication with Mr A was reasonable and appropriate and therefore did not uphold Mr A's complaint.

[Betsi Cadwaladr University Health Board - Medical records/standards of record-keeping](#)

[Case Number: 201807654 – Report issued in February 2020](#)

Mr X complained that the Health Board had created inaccurate or otherwise misleading medical records in relation to an operation he received some years earlier, which were relied on in providing care and treatment to him. Mr X was concerned that the lack of accurate detail within his medical records had resulted in his ongoing treatment being based on incorrect information.

The investigation found that the operation was appropriately described in Mr X's medical records. It found that referring to a substantial operation in simple terms risked minimising the considerable surgery Mr X

received and the skill of the Surgeons involved, however, it found that the records correctly recorded the nature of the surgery and there was no evidence that inappropriate records had been relied on in providing care and treatment to Mr X. For these reasons, the complaint was not upheld.

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

[Case Number: 201807297 – Report issued in February 2020](#)

Mr X said that following a biopsy in 2015, he was diagnosed with erosive oral lichen planus (a chronic inflammatory condition that affects the mucous membranes of the inside of the mouth – the lesions may cause burning, pain or other discomfort) and an oral fungal infection. He complained that despite this diagnosis, he did not receive any treatment from the Practice and was unaware that there was supposed to be a treatment programme in place until he transferred to another dental practice in late 2018.

The investigation found that whilst the Practice did not treat Mr X's condition and implement the management plan set out in a letter dated 26 February 2018 from the local Maxillofacial & Oral Surgery Clinic, this was not as a result of maladministration (in terms of mishandling or ignoring that letter) or service failure (in terms of poor clinical practice) on its part. The investigation found no evidence that the letter had been delivered to the Practice so it could not reasonably be criticised for not being aware, and not making Mr X aware of its contents, including the management plan.

Other than the management plan contained in that letter, none of the letters received by the Practice from the Maxillofacial & Oral Surgery Clinic could be construed as advising or instructing the Dentists to treat the lesions on Mr X's inner cheeks. Furthermore, the clinical advice obtained during the investigation indicated that, in the absence of an instruction to treat by the clinic, it would have been inappropriate for the Dentists at the Practice to proactively treat the(se) condition(s).

The complaint was therefore, **not upheld**.

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

[Case Number: 201901554 – Report issued in March 2020](#)

Mr Y complained that Hywel Dda University Health Board failed in its duty of care towards his father in law Mr X, when it inappropriately discharged him from the Emergency Department on 31 July 2018. Mr Y said that the decision to discharge Mr X caused a delay in his diagnosis and treatment.

The investigation found that the decision to discharge Mr X from the Emergency Department was in keeping with current practice and that there was no obvious reason to have admitted him to hospital at the time. There was no evidence to suggest that the Health Board's decision to discharge Mr X caused a delay in his diagnosis and ultimate treatment or that it caused Mr X any harm. The Ombudsman's Professional Adviser confirmed that the treatment provided to Mr X by the Health Board was always appropriate and generally of a high standard. Consequently, the complaint was not upheld, and no recommendations were made.

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

[Case Number: 201904489 – Report issued in March 2020](#)

Ms X complained that she received inadequate care when she attended the Emergency Department ("the ED") at the Royal Glamorgan Hospital ("the Hospital"). Specifically, Ms X complained that when she attended the ED an X-ray should have been performed due to pain she was experiencing in her neck.

The Ombudsman found that the clinical assessment of Ms X was largely appropriate, although he did consider that the clinician's documentation could have been improved upon. The Ombudsman found that there was no indication that an X-ray should have been performed based on Ms X's presenting symptoms when she attended the ED and, in any event, if an X-ray had been performed Ms X's care would not have

been different. The Ombudsman found that the management of Ms X's care was appropriate. The complaint was therefore **not upheld**.

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

[Case Number: 201900249 – Report issued in March 2020](#)

Mrs A complained about the care and treatment she received from the Health Board. Specifically, Mrs A complained that there had been a failure to diagnose and manage the pain she had been experiencing since undergoing a banding ligation procedure for her haemorrhoids.

The investigation found that there was no evidence that the banding ligation procedure caused the nerve damage Mrs A was experiencing. The investigation also found that, whilst it was unfortunate that the cause of Mrs A's pain had not been identified, the investigations undertaken by the clinicians to identify the cause of, and manage, Mrs A's pain had been appropriate.

The complaint was not upheld.

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

[Case Number: 201807686 – Report issued in March 2020](#)

Mrs X complained that the Health Board failed to provide appropriate care to her late husband, Mr X, after he was found to have an aneurysm (a swelling of the aorta, i.e. the main artery of the body) when a chest CT scan (a computerised tomography scan uses X-rays and a computer to create detailed images of the inside of the body) was undertaken in July 2017. Mrs X said that the scan had shown an aneurysm in the higher part of Mr X's lung. She was concerned that the Health Board failed to undertake further investigations to establish, in light of the discovery of the first aneurysm, whether he might have other aneurysms. Mrs X said that a second aneurysm ruptured in August 2017 which sadly resulted in his death at a hospital in the Swansea Bay University Health Board area.

The investigation found that the care provided by the Health Board had been appropriate. The CT scan of July 2017 was appropriately done and there was no indication for the radiologist to undertake further investigations in the light of the reported findings. Of note, the Radiology Adviser said that there was no abnormality (such as an aneurysm) visible in the chest, which included the lungs (where Mrs X believed the first aneurysm to have been located). The aneurysm that was identified was relatively small and below the level of the kidneys in the abdomen. It was reasonable for the radiologist not to arrange or request further urgent investigations considering this finding of a small aneurysm. The routine (non-urgent) referral to the vascular team was appropriate. It was very unfortunate that Mr X suffered an aorto-enteric fistula (an abnormal connection between the aorta and the intestines, stomach or oesophagus) which seemed to have involved the aneurysm. This was a rare event which had, in this case, catastrophic effects and a tragic outcome. The complaint was therefore **not upheld**.

[Early Resolution or Voluntary Settlement](#)

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

[Case Number: 201904856 – Report issued in January 2020](#)

Mrs X complained that Powys Teaching Health Board ("the Health Board") handled her complaint inadequately. In particular, Mrs X raised concerns about the Health Board's failure to update her on the progress of her complaint and the delay in the Health Board providing its full complaint response. The Ombudsman found that there were delays in the Health Board's handling of Mrs X's complaint and that the Health Board did not provide Mrs X with regular or meaningful updates on the progress of her complaint. The Health Board agreed to:

- a) Provide Mrs X with a fulsome written apology for the complaint-handling delays
- b) Make a redress payment of £250 to Mrs X to reflect the poor handling of her complaint.

Swansea Bay University Health Board - Other

Case Number: 201905066 – Report issued in January 2020

Miss A complained that her son, J, was not receiving the mental health treatment and social care he was entitled to. Miss A said that J had not been assessed adequately, and as a result, his learning disability status had been withdrawn.

The Ombudsman found that there was a dispute over the assessments the Health Board said it had undertaken, and the assessments Miss A believed had been undertaken. It was not clear what support package had been put in place, if any, for J.

The Ombudsman contacted the Health Board and it agreed to, within one month, arrange and conduct a multidisciplinary meeting with the Local Authority to establish what care package is available to J, and by whom it will be funded and delivered. Further, within three weeks of the meeting, to provide a full written explanation to Miss A to explain what treatment and/or support J has been identified as requiring, who is responsible for providing it, why J's learning disability status has been removed, and if it will be re-introduced.

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

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201905799 – Report issued in January 2020

Mr X complained that Cardiff and Vale University Health Board ("the Health Board") did not x-ray his daughter's magnetic shunt following an MRI scan to ensure the shunt was operating correctly or whether it required re-programming. Mr X further complained that his daughter suffered further damage to her brain as a result.

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

By 27 February:

- 1) Arrange a meeting with Mr X to discuss his concerns, subject to his availability;
- 2) Issue Mr X with a formal response letter within 15 days of the meeting addressing his concerns.

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

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201905511 – Report issued in January 2020

Mr X complained that he was refused medication for his mental health condition over a period of around 5 months after relocating to Wales.

Whilst Mr X's concerns dated back to 2016 and therefore substantially out of time for an investigation by this office, the Ombudsman was concerned that despite receiving a letter in September 2019, advising him that his concerns relating to A&E and the mental health service were ongoing, he had not received any further correspondence from the Health Board addressing these issues.

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

Within thirty working days:

- a. Apologise to Mr X for the delay in responding to his complaint

- b. Issue a response letter which addresses Mr X's outstanding concerns.

A GP practice in the Hywel Dda Health Board's area - Prescription dispensing

Case Number: 201904716 – Report issued in January 2020

Mr X, a patient of "The Surgery", complained that he had not received repeat prescriptions and medications due to failures by the surgery. Mr X had made five written complaints to the Surgery in relation to this.

The Ombudsman concluded that the Surgery had not received or provided response to two of the complaints and that the response that had been provided did not appear to fully address the matters raised.

The Surgery agreed to re-consider the three complaints and responses that had been provided and to consider the two complaints it had not received within 10 working days. The Surgery also agreed to provide a comprehensive formal written response dealing with all the complaints made by Mr X, in accordance with "Putting Things Right" and providing relevant evidence in support, within 20 working days.

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

Boots The Chemists Ltd - Prescription dispensing

Case Number: 201904939 – Report issued in January 2020

Mr B complained that a branch of Boots The Chemist in his area had incorrectly dispensed the wrong medicines for his mother. He also complained that it had failed to deal with his complaint correctly when he contacted it.

It appeared that there was some confusion about what Mr B was actually complaining of and there appeared to be a need for him to sit with the store manager and pharmacist in order to establish if there was an issue and whether Boots was able to provide him with a reasonable response to his complaint.

The Ombudsman contacted Boots and it agreed to write a letter to the complainant's son within 5 working days of the date of my decision letter:

- a) Offering him a choice of two dates for him to meet with yourself and/or a pharmacist at its Queen Street store during January 2020 to establish if there any issues detailed in his complaint that require further investigation
- b) Provide him with a summary of the meeting and detail any actions proposed by the Pharmacy, if any, as a result of it.

This letter should be sent to him within 10 working days of the meeting.

The Ombudsman was satisfied that this would resolve Mr B's complaint at this stage.

Betsi Cadwaladr University Health Board - De-Registration

Case Number: 201903041 – Report issued in January 2020

Mr A complained about Betsi Cadwaladr University Health Board's ("the Health Board's") investigation into his complaint about his former GP's decision to remove him from the Practice's patient list due to irretrievable breakdown in the doctor/patient relationship.

The Ombudsman decided there were shortcomings in both the Health Board's investigation including its delay in providing a response to the complaint, and process shortcomings were identified in the way Mr

A's former GP dealt with the decision to delist him.

The Health Board agreed to write to Mr A and provide an explanation recognising the former GP's shortcomings in the delisting process. The Health Board also agreed to apologise to Mr A for the shortcomings identified in the Health Board's investigation and for its delay in providing a timely formal response to his complaint.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201905230 – Report issued in January 2020

Mr X complained that whilst he was a patient at Wrexham Maelor Hospital in July 2019, his blood sugar levels rose above its normal range to 27.1mmols, but the Health Board refused to give him rescue treatment in the form of fast acting insulin.

The Ombudsman noted that as part of the Health Board's investigation, it had concluded that it would normally provide rescue treatment when a patient's blood sugar levels rose to 20mmols. On that basis, it appeared that the Health Board had omitted to acknowledge the extent of Mr X's blood sugar levels when it responded to his complaint. After making some enquiries the Ombudsman also became aware that Mr X had written a further letter dated 4 December 2019, which he had sent to the Health Board after making his complaint to the Ombudsman's office. The Ombudsman concluded that it would be helpful to Mr X to receive a further explanation from the Health Board regarding the points he had raised.

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

- a) To provide a written response directly to Mr X in relation to his blood sugar levels rising to 27.1mmols, and his letter dated 4 December 2019, within 30 working

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) Case Number: 201904805 – Report issued in January 2020

Miss X complained about the care that was afforded to her mother at St Woolos Hospital in November 2018 following a fall that she sustained at home. Miss X said that she had attended a local resolution meeting and the Health Board had provided a written response to her complaint, but she complained that matters remained unresolved.

The Ombudsman took into account that as part of the Health Board's investigation, it had already provided a reasonable explanation to the majority of points raised by Miss X, and it had carried out relevant action to address and/or resolve matters, which included an apology for the failings identified; a reminder issued to relevant staff about their responsibilities; a review of the nursing documentation to ensure that correct assessments and equipment are in place to support patient care. The Ombudsman also noted that Miss X had outlined a number of points which had not been specifically raised with the Health Board and/or arose as supplementary questions to the Health Board's response. He concluded that it would be helpful for Miss X to receive an explanation to the points which he highlighted.

The Health Board agreed to provide Miss X with a written response to the point highlighted within 2 months of the date that the decision is issued.

[Swansea Bay University Health Board - Continuing care](#) Case Number: 201905021 – Report issued in January 2020

Ms X complained to the Ombudsman about the manner in which an Independent Review Panel it had set up to consider claims of eligibility for Continuing Health Care (CHC) funding had dealt with an application on behalf of her late mother. The Ombudsman noted that the Health Board had failed to respond to Ms X following specific procedural concerns she had raised about the review Panel's process.

The Health Board agreed, by 15 February 2020 to provide Ms X with a further response to Ms X covering

the specific concerns, she raised in relation to the Independent Review Panel's actions in considering her review of her late mother's eligibility for CHC funding.

[Welsh Ambulance Services NHS Trust - Ambulance Services](#) [Case Number: 201906109 – Report issued in February 2020](#)

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 outside hospital](#) [Case Number: 201906007 – Report issued in February 2020](#)

Ms X complained about delays in the Health Board's handling of her complaint about her father's care, what she considered to be factual inaccuracies in its response letter and its decision that shortcomings in his care did not amount to a qualifying liability.

The Ombudsman declined to investigate the complaint about the decision in respect of breach of duty leading to a qualifying liability as it is not his role to make such determinations. He was, however, concerned at delays in the complaint handling and also considered that a mutually agreeable position could be reached in respect of perceived factual inaccuracies.

In settlement of the complaint, the Health Board agreed to explain why the delays occurred and apologise for them, as well as to reach an agreed position in respect of factual accuracy.

[Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201905341– Report issued in February 2020](#)

Mr X complained about the standard of post-operative wound care provided to his late father, Mr Y. In particular, he felt that Mr Y had contracted a wound infection following discharge home, whilst under the care of the District Nursing team. He complained that this resulted in further surgery being necessary.

The Ombudsman noted that the response to Mr X's complaint did not contain any detail about the nature or number of visits or specific wound care provided to Mr Y post operatively by the district nursing team. The Health Board agreed to provide a further response to Mr X to answer his concerns about the standard of wound care at home provided by the District Nursing team. It agreed to provide this response within 6 weeks of the date of this letter.

[GP Surgery in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital](#) [Case Number: 201906402 – Report issued in February 2020](#)

Mr A complained that his wife was only prescribed with a five-day course of antibiotics following a diagnosis of a urinary tract infection. He believed that a seven-day course should have been prescribed as was described on the packaging by the manufacturer. He complained to the surgery and he received a written letter of response from it. He was unhappy with the lack of detail provided in the letter.

The Ombudsman found that the response letter was lacking in detail. It did not provide an explanation of what, if anything, had been discovered as learning points from reviewing his complaint and what action it would take as a result of any findings.

The Ombudsman contacted the surgery and it agreed to write a response letter to the complainant:

- 1) Providing an explanation of any issues discovered as a result of the review of his wife's treatment that it stated it was going to undertake in its initial response letter to him.
- 2) How it proposes to take any learning points forward to improve its service in future.

This should be completed within 20 working days.

The Ombudsman believes that this is a satisfactory resolution to Mr A's complaint.

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

[Case Number: 201905532 – Report issued in February 2020](#)

Mr X attended the Health Board's Emergency Department in August 2019 complaining of constipation and urine retention. He said that the Health Board had failed to treat him for constipation, and it omitted to remove a catheter prior to his discharge home which resulted in him experiencing pain and discomfort. Mr X submitted his initial complaint to the Health Board in August 2019, and he received the Health Board's response, but he remained dissatisfied. He therefore sent a further letter to the Health Board on 22 October 2019, raising his further concerns. Mr X complained to the Ombudsman that the Health Board failed to respond to that letter.

After making enquiries with the Health Board, the Ombudsman noted that it had not received Mr X's letter, so it was unaware of the further concerns which he had raised. The Ombudsman concluded that it would be helpful for Mr X to receive a response from the Health Board, in order to address his concerns and resolve the complaint.

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

1. To provide a written response to Mr X's letter dated 22 October 2019 within 2 months of the date that the Ombudsman's decision is issued.

The Ombudsman was satisfied that the action which the Health Board had said it would take was reasonable.

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

[Case Number: 201904506 – Report issued in February 2020](#)

Ms X complained to the Health Board about the service that her daughter received from the Endoscopy Unit. Ms X received the Health Board's response to her complaint, but she remained dissatisfied. Therefore, she sent a further email to the Health Board on 9 April 2019, raising two questions which she considered had not been addressed. Ms X complained to the Ombudsman that the Health Board failed to respond to her email.

After making enquiries with the Health Board, the Ombudsman noted that it had received Ms X's email, but once it became aware of her intention to complain to the Ombudsman, it stopped preparing its response. The Health Board acknowledged that it should have sent a response to Ms X. The Ombudsman concluded that it remained helpful for Ms X to receive a response to her email.

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

- a) To provide a written response to Ms X's email of 9 April 2019 by 28 February 2020.

The Ombudsman was satisfied that the action which the Health Board had said it would take was

reasonable and would resolve Ms X's complaint.

Cardiff and Vale University Health Board - Clinical treatment outside hospital

Case Number: 201905802 – Report issued in February 2020

Mrs X complained to the Ombudsman about the treatment and therapies she had received from the Health Board in relation to her Mental Health illness. She was concerned about the lack of treatment she received for her Post-Traumatic Stress Disorder (PTSD) which had previously been diagnosed and for which a course of therapy had been provided by the Health Board. Mrs X was particularly aggrieved the Health Board's refusal to refer her to its PTSD service.

Enquiries by the Ombudsman identified that the Health Board's clinical staff were of the view that Mrs X did not appear to have PTSD. However, no explanation of their rationale for this conclusion was provided in the Health Board's response to Mrs X's complaint about its refusal to refer her to its PTSD service. The Health Board agreed to provide, within 4 weeks:

- a) An explanation of why it does not consider that Mrs X has PTSD contrary to her previous diagnosis and referral and that this is the reason she is not being referred to the trauma stress service.
- b) An apology for not providing this explanation in its earlier response to her.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201904927 – Report issued in February 2020

Mr H complained that he was told by the consultant surgeon responsible for his care that his acoustic neuroma tumour had grown but that a consultant oncologist later stated that it had not grown and that he had been misinformed previously. Mr H told us that he was extremely distressed to be told that the tumour had grown and felt that this could have been avoided if the correct information had been provided sooner. Mr H complained that it took Cardiff and Vale Health Board too long to inform him about the results of his scan in August 2018. Mr H was also concerned that a multi-disciplinary team meeting had not been made aware of his full medical history including previous stereotactic radiotherapy.

The Ombudsman noted evidence provided following a further review of Mr H's scans that the tumour had grown marginally in length. The Ombudsman was concerned however that miscommunication had occurred which resulted in Mr H being given confusing and contradictory information about the size of the tumour by different clinicians within the Health Board. The Ombudsman also considered that the length of time it took for the Health Board to provide Mr H with the result of the August 2018 scan was excessive.

In response to the Ombudsman's concerns, the Health Board agreed to carry out the following actions within 4 weeks:

- a) To apologise to Mr H in writing for the delay in providing the results of the MRI scan which was carried out on 13 August 2018.
- b) To apologise to Mr H in writing for poor communication in relation to information provided about the size of the tumour.
- c) To make a payment of £250 to Mr H in respect of distress caused by the Health Board's miscommunication.
- d) To write to Mr H providing further information to clarify the Health Board's findings in relation to the scan of 13 August 2018.
- e) To invite Mr H to meet with representatives of the Health Board to discuss the findings in more detail if he wishes to do so.

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

[A Dental Practice in the area of Swansea Bay University Health Board - Clinical treatment outside hospital](#) Case Number: 201905235 – Report issued in February 2020

Ms A complained about the care and treatment she received from the Practice during and after a (second) tooth extraction in 2019. Ms A said that the dentist permanently damaged her teeth and the dentures that were initially provided were unsuitable. Ms A was unhappy with the Practice's management of the complaint.

The Ombudsman found that the Practice's complaint response did not provide enough information to demonstrate that there had been a thorough review of the care and treatment provided to Ms A.

The Ombudsman contacted the Practice and **within 20 working days** it agreed to:

- a) Reconsider Ms A's complaint by carrying out a thorough review of the care and treatment she received and to provide her with a comprehensive response to her complaint.

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

Case Number: 201902579 & 201902427 & 201902286 – Report issued in February 2020

The Ombudsman received complaints from a firm of solicitors on behalf of a number of representatives of claimants for retrospective NHS funded continuing health care ("CHC" - a package of care funded by the NHS where an individual's primary need is health-based). The complaints related to delays in the determination of such claims.

The Welsh Assembly Government (as it then was) set up a system whereby retrospective claims for the period 1 April 2003 to 31 July 2013 which had not previously been submitted to individual health boards were to be submitted to the All Wales Retrospective Continuing Health Care Reviews Project ("the Project"), hosted by Powys Teaching Health Board ("the Health Board"), by 31 July 2014. In June 2014 the Welsh Government issued guidance indicating that such claims should take no longer than 2 years to determine. When the complaints were made to the Ombudsman all the claimants had been waiting over 3 years for a determination of their claims. On 30 June 2019 the Project closed and all outstanding claims were transferred to their respective health boards.

The Ombudsman had previously investigated similar complaints about delay in the determination of another group of retrospective CHC claims by the Project. The Health Board agreed to settle these complaints in line with the recommendations contained in the Ombudsman's previous report. The Health Board agreed to:

- b) Apologise to the complainants for the delay in determining their claims.
- c) Offer a payment of £125 to each complainant in recognition of the delay experienced.
- d) Offer the same payment to all other claimants in the same situation.

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

Case Number: 201807660 & 201807656 – Report issued in February 2020

Mr A complained about the care and treatment he received from both the Medical Practice and Aneurin Bevan University Health Board ("the Health Board"). Mr A's concerns about the Medical Practice included the GP referring him, without his consent, for an assessment at a mental health unit as well as the Medical Practice's handling of his complaint. Mr A's concerns about the Health Board related to his care during his inpatient stay, poor communication and complaint handling.

The Ombudsman's investigation concluded that the care provided to Mr A by the GPs was broadly reasonable and appropriate. However, the investigation identified some administrative shortcomings. As part of its settlement response, the Medical Practice provided clarification and the detailed measures it had in place. The Ombudsman was satisfied that the measures the Medical Practice had identified were reasonable and therefore the complaint against the Medical Practice was settled.

In relation to Mr A's concerns about the Health Board, the Ombudsman found some shortcomings in his care. The Health Board agreed as part of a settlement that it would apologise to Mr A for the failure to provide him with medication on discharge and the shortcomings in record keeping/communication. The Health Board also agreed to revise its discharge policy so that it emphasised the importance of take home medication on discharge.

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

[Case Number: 201904831 – Report issued in March 2020](#)

Mrs A complained about the care and management of her husband at the Emergency Department ("ED") at Bronglais Hospital. Mrs A said that the ED clinicians assumed that her husband's symptoms were due to glyphosate poisoning and failed to consider a differential diagnosis. The Ombudsman's investigation found that the National Institute of Health and Care Excellence ("NICE") guidance on diagnosis and management of headaches in over 12s advises that a headache with certain additional features should be considered for further investigations such as a CT head scan. The Ombudsman said that Mr A had several of these additional features which warranted further investigations and that the ED clinician's should have considered an alternative diagnosis of a subarachnoid haemorrhage and a CT scan undertaken ideally as soon as he was initially assessed by the ED doctor. The fact that this had not happened represented a shortcoming in Mr A's care.

In settling this complaint, the Health Board agreed to apologise to Mr and Mrs A for the failure to consider an alternative diagnosis and inadequate complaint handling. Additionally, it agreed to share this case with those involved in Mr A's case as part of reflective learning as well as providing training to all its medical staff in the ED on the diagnosis and management of headaches using an anonymised version of this case.

[Welsh Health Specialised Services Committee – Funding](#)

[Case Number: 201906059 – Report issued in March 2020](#)

Ms P's doctor made an independent patient funding referral application for her to receive specialist treatment for a rare type of cancer. The Committee's policy recommended that a biopsy should be taken to confirm the diagnosis before funding was awarded. Ms P said the Committee insisted that she undergo an invasive biopsy despite an email from the leading Specialist in England stating that a biopsy was unnecessary, not current practice and carried significant risk.

The Committee confirmed to the Ombudsman that the policy was due to be reviewed in 2020 to ensure it remained appropriate and in line with current clinical practice. It agreed to invite Ms P to meet personally with the Chair of the review panel to discuss her experience of the process and her views on any proposed amendments to the policy before the end of the consultation period at the end of August 2020. The Ombudsman considered this was reasonable and so the matter was resolved on that basis.

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

[Case Number: 201906854 – Report issued in March 2020](#)

Mr X complained about the manner in which the Health Board had dealt with allegations made against his son whilst he had been a hospital inpatient. He raised concerns that the Health Board had not properly investigated the matter, and that the Health Board's response to one of the key points of his complaint was still outstanding.

The Ombudsman contacted the Health Board. The Health Board agreed to provide the further response to

Mr X's complaint by 31 March 2020.

[Betsi Cadwaladr University Health Board - Other](#)
[Case Number: 201906526 – Report issued in March 2020](#)

Mr X complained that Betsi Cadwaladr University Health Board (“the Health Board”) had not provided him with a satisfactory response to address all his concerns, specifically in relation to comments made by a consultant about cancer.

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

By 16 April 2020:

- a) Provide Mr X with a detailed response addressing his concerns in relation to the comments made by the consultant.

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

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#)
[Case Number: 201906483 – Report issued in March 2020](#)

Mrs X complained about the Health Board's handling of her complaint into the delay in notification of diagnosis of Chronic Lymphocytic Leukaemia in respect of her late husband. Mrs X complained that it took the Health Board 21 months to issue its final response to the complaint.

The Ombudsman noted that the Health Board had within the complaints correspondence offered its apologies for the continued delay, together with its reassurance that Mrs X's concerns were receiving attention. However, the Health Board had not explained the reasons for the delay, neither had Mrs X specifically raised that complaint. The Ombudsman concluded that it might have been helpful for Mrs X to receive an explanation about any shortcomings in the complaints handling process. After making some enquiries with the Health Board, it agreed to undertake the following action in settlement of the complaint:

- a) to provide a written response to Mrs X within 30 working days from the date the Ombudsman issued his decision to:
 - explain the reasons for any delay caused in the complaints handling process;
 - offer an apology for any shortcomings identified; and
 - explain whether any improvement actions or organisation learning resulted from the complaint.
 - to make a payment of £250.00 to Mrs X in recognition of the time and trouble caused by the handling of the complaint.

[Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital](#)
[Case Number: 201904942 – Report issued in March 2020](#)

Mrs X complained about the Health Board's treatment of her mother, particularly that it failed to diagnose her heart condition, which led to her premature death, and that she was unaware of the severity of her kidney condition. Mrs X also complained as a result that her mother was not receiving appropriate treatment.

The Ombudsman found that the Health Board's response did not wholly address Mrs X's complaint and left her in a position of feeling that her mother's care had not been explained. The Ombudsman considered that a further response was required to address Mrs X's concerns. The Health Board agreed to

provide Mrs X with an appropriate response, in accordance with its regulations, to her outstanding queries in respect of her mother's heart and kidney conditions and her cause of death. The Health Board also agreed within a month of its response to meet with Mrs X to discuss her complaint and mother's care.

[Abertawe Bro Morgannwg University Health Board - Appointments/admissions/discharge and transfer procedures](#)

[Case Number: 201807792 – Report issued in March 2020](#)

Mrs A complained that Abertawe Bro Morgannwg University Health Board (now Swansea Bay University Health Board) ("the Health Board") had not given her 6-monthly appointments at its Glaucoma Assessment Clinic ("the Clinic") in accordance with her clinical need.

The Ombudsman noted that the Health Board had acknowledged that it had not given Mrs A these Clinic appointments. He found that Mrs A had been at risk of irreversible harm or a significant adverse outcome because of these Clinic appointment failings. He also established that Mrs A had made 4 separate complaints to the Health Board, about her appointments at the Clinic being delayed and/or cancelled, during a 2-year period. He determined that Mrs A had suffered some injustice, in the form of prolonged inconvenience and understandable anxiety, because of the failings identified. He considered that it would be appropriate to try settling Mrs A's complaint. He took into account, when reaching that view, systemic changes that the Health Board had made to improve the capacity of its Glaucoma Service and Mrs A's recent glaucoma-related appointments.

He asked the Health Board if it would be willing to settle Mrs A's complaint by writing to her to acknowledge its Clinic appointment failings, to apologise for them, to give her information about how it has improved the Clinic's capacity and to assure her that it will make every reasonable effort to ensure that she receives timely Clinic appointments in future. The Health Board agreed to write to Mrs A in the manner proposed. The Ombudsman considered, as a consequence, that Mrs A's complaint had been settled.

Community Facilities, Recreation and Leisure

[Early Resolution or Voluntary Settlement](#)

[Newport City Council - Cemeteries/Graves/Headstones](#)

[Case Number: 201903676 – Report issued in January 2020](#)

Mrs X complained that the Council prepared a grave for her Grandmother in the wrong cemetery. As a result of this, the grave was not prepared to an appropriate standard. The Council also failed to follow its complaints procedure correctly.

The Ombudsman noted the Council's acceptance that the grave had been dug in the incorrect cemetery and the agreement by the relevant manager that this had meant there was insufficient preparation time. The Council accepted that there had been errors in its handling of the complaint.

The Council agreed to apologise and pay Mrs X £250 in relation to both the errors made regarding the location of the grave and the complaints handling. It also agreed to update the Ombudsman when a proposed grave digging procedure was implemented, which included checks to be made for grave preparation.

Complaints Handling

Upheld

Cafcass Cymru - Various Other

Case Number: 201806230 – Report issued in January 2020

Mrs B complained about Cafcass Cymru's ("CC's") handling of her formal complaint about a member of its staff.

The Ombudsman found that CC had mis-applied its Complaints Guidance which resulted in an element of Mrs B's complaint being rejected erroneously. When Mrs B challenged this, CC failed to give her proper reasons for its decision.

Regarding Mrs B's concerns about CC's investigation, there was a failure to interview Mrs B about her complaint, and to identify and secure all the available evidence. The Ombudsman also found that CC had failed to keep reliable records of a meeting subject to the complaint. Although CC provided Mrs B with a copy of its notes of this meeting on request, it had given her reasonable cause to believe that minutes of the meeting were being taken that would be shared with her. These failings caused uncertainty for Mrs B about the findings of CC's complaint investigation and undermined her confidence in the fairness of its process, and the findings reached.

The Ombudsman did not uphold Mrs B's complaint that CC failed to appoint an impartial person to investigate her complaint as he found that an independent investigating officer was engaged.

The Ombudsman recommended that CC apologise to Mrs B and pay her £500 for the failings identified. CC also agreed to invite Mrs B to submit a supplementary statement to the meeting notes to be put on the case record; to review its current practice of not obtaining evidence from former members of staff, and to review the training requirements of its investigating officers.

Flintshire County Council - Planning and Building Control

Case Number: 201806094 – Report issued in January 2020

Ms X complained that the Council failed to adequately deal with matters relating to the temporary siting of a portable building close to her home, which is a Grade II listed building. In particular, the Council failed to consider the impact on Ms X's home including protecting the Listing's setting, failed to take enforcement action following unauthorised construction work and there being no current valid planning permission in place for the portable building, demonstrated bias towards the applicants as they are the Council's tenants, rendered her home valueless by allowing the portable building to remain in situ and failed to deal with Ms X's complaint properly and failed to respond to letters and emails.

The Ombudsman's investigation found that documentation relating to the portable building application was scant and records of site visits and meetings were missing. The Council could not provide clear reasoning as to why it had decided not to take enforcement action, although the Ombudsman found that it was reasonable not to do so while the application was in abeyance. Whilst the Ombudsman was satisfied that the Council had made attempts to regularise the application, it had let the matter drift for over two years and he was disappointed that at no point had a timetable been put in place for the application to be validated or indeed, what the Council would do if it could not be validated.

The Ombudsman upheld the majority of Ms X's complaints but did not agree that the Council had demonstrated bias towards the applicants or that Ms X's home had been rendered valueless.

The Ombudsman recommended that the Council should apologise to Ms X and share his report with the

Council's planning department to ensure lessons were learnt so that in future it could demonstrate good administration of its planning cases. The Ombudsman also recommended that the Council develop a plan (set out within a reasonable timeframe) with the applicant to regularise its application, including what will happen if the timetable was not met, so the Council can proceed with a decision regarding the siting of the portable building and other minor construction works. The Ombudsman also recommended that the Council kept Ms X updated at all stages of the process.

Powys County Council - Various Other

Case Number: 201807772 & 201807771 – Report issued in March 2020

Mr X and Mr Y were two former elected members of Powys County Council ("the Council"). They had held portfolio roles within the Council but had stood down by the time events leading to their complaints occurred. Both complained about public statements made by the now former Chief Executive Officer ("former CEO") of the Council during a live webcast relating to a published critical inspection report concerning its Children's Services Department. They said that the former CEO's comments were defamatory and first complained to the Council in November 2017 about damage caused to their reputations. They later also complained about the delay in having their concerns investigated. Mr X and Mr Y also said that when received (on 28 February 2019) the response, which was provided after a significant delay, showed their concerns had not been investigated properly or professionally, and that the officer who had conducted it (a Solicitor at the Council) had a close working relationship with the former CEO. Therefore, they said, he could not have undertaken it objectively.

Whilst not for him to determine whether any comments were defamatory, the Ombudsman considered the Council's Corporate Complaints Policy ("the Policy") and how the investigation was conducted as a whole. He found that Mr X and Mr Y's concerns had been considered in a muddled way, having initially not been dealt with under the Policy, so leading to the significant delay in completing the investigation. Furthermore, the Solicitor charged with undertaking it was an inappropriate choice given he had been highlighted in the original complaint as potentially being a witness to relevant events, and so there was a potential conflict of interest. The Policy allowed for "serious" matters (not defined) to be investigated by someone external to the Council. The Ombudsman felt that a complaint against the Council's most senior officer was "serious". There was no contemporaneous record of the meeting with the former CEO as part of the investigation, which the Ombudsman found to be poor practice in complaint handling and to be maladministration. Whilst noting some difficulties outside the Council's overall control, the time taken to respond to Mr X and Mr Y's complaints was far too long - in part a product of the initially muddled approach. The Ombudsman upheld the complaints.

The Council accepted the Ombudsman's recommendations to apologise to both Mr X and Mr Y and to offer both a payment of £1000 in recognition of the distress caused by the serious failings in complaint handling. The Council also agreed to review its Policy giving particular consideration as to when an independent investigator should be appointed.

Not Upheld

Cardiff Council & Cardiff and Vale University Health Board - Adult Social Services & Clinical treatment outside hospital

Case Number: 201901127 & 201901126 – Report issued in March 2020

Mr X complained that a second opinion was sought from a senior psychiatrist (a Professor of Psychiatry) outside of the Community Mental Health Team ("CMHT") responsible for his care and the resulting diagnosis was unreasonably disregarded by the CMHT. He was aggrieved that the (draft) Care and Treatment Plan prepared for him in January 2019 was inadequate. Mr X was of the view that the draft plan was insufficiently detailed or meaningful. He also considered that the planned therapy was inappropriate and would not fully meet his needs.

In 2016 Mr X was diagnosed, by a psychiatrist from the CMHT, with Autistic Spectrum Disorder (a

condition that affects social interaction, communication, interests and behaviour). Mr X was unhappy with the diagnosis. A Professor of Psychiatry, who assessed Mr X in 2017, concluded that Mr X did not meet the criteria for ASD but that a diagnosis of Borderline (Emotionally Unstable) Personality Disorder (a disorder of mood and how a person interacts with others) was suitable. Mr X agreed with this diagnosis. In 2018 Mr X was assessed by a Consultant Psychiatrist from the CMHT and a diagnosis of ASD with BPD traits was made. The draft Care and Treatment Plan of January 2019 was prepared on the basis of the latest diagnosis.

The investigation found that it was not inappropriate for the Consultant Psychiatrist from the CMHT to come to a different conclusion to that which was reached by the Professor of Psychiatry. The draft Care and Treatment Plan was found to describe an appropriate approach to addressing the identified needs and goals agreed with Mr X. There were clearly identified and achievable outcomes with specific interventions and appropriate responsibility in supporting Mr X. (i.e. the plan was appropriate to Mr X's identified needs and had adequate and reasonable interventions and outcomes). Furthermore, Mr X's management had been appropriate, focused on his individual assessed needs and was reasonable. Mr X's complaints were therefore, not upheld.

Early Resolution or Voluntary Settlement

Betsi Cadwaladr University Health Board - Health

Case Number: 201905379 – Report issued in January 2020

Mrs X complained that the Health Board had failed to provide a substantive response to her complaint which she made on 27 September 2019.

During his enquiries the Ombudsman established that the Health Board had not provided a PTR response to Mrs X's complaint. 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 delay in responding to her complaint and for failing to provide meaningful and regular updates
- b) provide an explanation for the delay
- c) provide a PTR response.

Aneurin Bevan University Health Board - Health

Case Number: 201905029 – Report issued in January 2020

Mr X complained that the Health Board had not returned his calls to enable him to make a complaint. Mr X wanted to raise a concern about the service provided when he was unable to access care at his GP surgery.

During his enquiries the Ombudsman established that the Health Board had dealt with his concerns informally. The Health Board had evidenced to the Ombudsman that it had given serious consideration to Mr X's concerns and how it could provide a service to Mr X in the future. However, the Ombudsman found that it may be helpful for the Health Board to clarify this in writing to Mr X. Further to the Ombudsman's enquiries, the Health Board agreed to complete the following in settlement of Mr X's complaint by 10 February 2020:

- a) Write to Mr X to set out:
 - the future arrangements for care should Mr X be unable to attend the surgery in future;
 - how Mr X may make a complaint to the Health Board in future, should he need to do so.

Aneurin Bevan University Health Board - Health

Case Number: 201905683 – Report issued in January 2020

Mr X had complained to Aneurin Bevan University Health Board (“the Health Board”) about the poor handling of his referral and a delay in receiving his appointment. Although the Health Board had responded to Mr X, he was not satisfied with the response.

In considering Mr X’s complaint, the Ombudsman was concerned that the Health Board had not fully addressed all of the issues that Mr X had raised, and the Health Board therefore agreed to complete the following actions in settlement of the complaint:

Within the next 30 working days:

- a) Provide a further explanation to Mr X in respect of a missing referral, explain how this happened and what, if anything, has been done to prevent this from happening again.
- b) Provide a further explanation regarding what happened following a telephone call made by Mr X’s GP to the consultant.

Betsi Cadwaladr University Health Board - Health

Case Number: 201905719 – Report issued in January 2020

Mr X complained that the Health Board had failed to respond to his complaint about the treatment provided to his late partner, which he made to it on 20 February 2019.

Although the Health Board had provided a partial response to Mr X and a holding letter, the Ombudsman was concerned that there had been some miscommunication and delays.

In settlement of Mr X’s complaint the Health Board agreed to apologise to Mr X for the delays and a issue a full response by 14 February 2020.

Cardiff and Vale University Health Board – Health

Case Number: 201905984 – Report issued in February 2020

Mr A complained that Cardiff and Vale University Health Board (“the Health Board”) had failed to respond to his complaint in a timely manner. Mr A complained to the Health Board in April 2019. The Health Board initially responded to him in June. The complainant was unhappy with the response and re-contacted the Health Board in July. The Health Board sent Mr A an email in September and agreed to arrange a meeting with him to discuss any outstanding issues. The email stated that they would contact him with some available dates for the meeting. Mr A had not received anything further from the Health Board when he complained to the Ombudsman in January 2020.

The Ombudsman was concerned at the lack of communication by the Health Board.

He contacted the Health Board and it agreed to:

- a) write a letter to the complainant apologising for the delay in dealing with his complaint.

It agreed to complete this within 20 working days of my decision letter to the complainant.

The Ombudsman considers that this is an appropriate early voluntary resolution to this complaint by the Health Board.

Betsi Cadwaladr University Health Board – Health

Case Number: 201906060 – Report issued in February 2020

Mrs G complained about care provided to her mother by Betsi Cadwaladr University Health Board (“the Health Board”) at Ysbyty Gwynedd hospital in the last days of her life. Mrs G was concerned that an end of life care plan was commenced without obtaining appropriate consent and that the Health Board discontinued medications that could have reduced her mother’s suffering.

The Ombudsman considered that the Health Board had not directly addressed Mrs G’s concerns regarding consent in its response and that it had not had an opportunity to consider Mrs G’s concerns regarding the discontinuation of medications.

The Health Board agreed to provide within 6 weeks a further response to Mrs G under the Putting Things Right Process to address the following issues:

- a) Whether the appropriate process was followed in relation to providing consent for the commencement of the end of life care plan in respect of Mrs G’s mother.
- b) Whether the appropriate process was followed in relation to the discontinuation of medications prescribed in the end of life care plan in respect of Mrs G’s mother.

The Ombudsman considered that the agreed actions represented a reasonable settlement of the complaint.

Cardiff Council - Roads and Transport

Case Number: 201905959 – Report issued in February 2020

Miss X complained about the lack of civil enforcement officers being sent to her street by the Council. Miss X also said that despite the Council agreeing to increase the patrol, this has not been done.

During his enquiries the Ombudsman established that whilst the Council had provided a complaint response to Miss X it was not comprehensive. The Council agreed to complete the following in settlement of Miss X's complaint by 19 February 2020:

- a) Provide a comprehensive complaint response to include the following:
 - an explanation of how it has increased the enforcement visits and the outcome of those visits
 - whether there is an intention to repeat these going forward, and if so, on what basis
 - An explanation of the powers of the Council in relation to enforcement.

Betsi Cadwaladr University Health Board - Health

Case Number: 201906015 – Report issued in February 2020

Mr X complained that whilst waiting for a prescription at a hospital, a nurse had deliberately broken patient confidentiality in an attempt to humiliate him and had announced to the waiting room what tablets he was being prescribed.

In considering Mr X's concerns, the Ombudsman noted that the complaint to Betsi Cadwaladr University Health Board (“the Health Board”) had been dealt with as an on the spot complaint and had not been considered under the Putting Things Right complaints procedure. In settlement of the complaint the Health Board agreed to provide a detailed written response to Mr X in line with its complaints procedure, within the next 30 working days.

Powys Teaching Health Board - Health

Case Number: 201906149 – Report issued in February 2020

Mrs X complained that she had submitted a complaint to Powys Teaching Health Board (“the Health Board”) on 29 July 2019 and despite numerous attempts to contact the Health Board, she had still not received a response.

In considering her complaint, the Ombudsman was concerned that Mrs X had not yet received a response to her complaint. The Health Board explained that the delay had been caused by the number of parties that needed to be contacted in order to fully assess the concerns Mrs X had raised. The Health Board however recognised the inconvenience that the delay has caused Mrs X and in settlement of the complaint, the Health Board has agreed to:

By 14 February 2020

- a) Apologise to Mrs X for the delay in responding to her complaint.
- b) Issue a response letter.

Swansea Bay University Health Board - Health

Case Number: 201906148 – Report issued in February 2020

Mr X complained that he is still waiting for a payment of £250 from the Health Board. Mr X said that the Health Board offered this payment due to its delay in providing a response to a complaint he had made. The Ombudsman established that the Health Board had failed to pay £250 to Mr X. Further to the Ombudsman's enquiries, the Health Board agreed to the following in settlement of Mr X's complaint by 25 March 2020:

- a) Provide a written apology to Mr X for the delay in providing £250
- b) Provide Mr X with an explanation for the delay
- c) Pay Mr x £250.

Hywel Dda University Health Board - Health

Case Number: 201906087 – Report issued in February 2020

Ms X complained about a lack of updates or a response from the Health Board to her complaints relating to her son's care and treatment.

During his enquiries the Ombudsman established that the Health Board had failed to provide regular and meaningful updates to Ms X or provide a response to her complaint. The Health Board agreed to complete the following in settlement of Ms X's complaint by 28 February 2020:

- a) Provide a written apology to Ms X for the lack of regular and meaningful updates
- b) Pay her £250 for her time and trouble in making her complaint to the Ombudsman
- c) Provide Ms X with a copy of the Serious Incident Report (“SIR”)
- d) If Ms X is not provided with the SIR within the agreed timeframe due to external factors beyond the Health Board's control, Ms X is updated accordingly with the reasons and an expected completion date
- e) Ms X will be able to make a new complaint to the Health Board, if following receipt of the SIR, she still has unanswered queries.

Ceredigion County Council - Various Other

Case Number: 201906875 – Report issued in March 2020

Mr X complained about a lack of acknowledgement or response from the Council when he escalated his

complaint to stage two.

During his enquiries the Ombudsman established that the Council had failed to acknowledge, provide meaningful updates or a complaint response to Mr X. The Council agreed to complete the following in settlement of Mr X's complaint by 16 April 2020:

- a) Provide an apology to Mr X for the failure to acknowledge his stage 2 complaint
- b) Provide an apology to Mr X for failing to provide meaningful updates
- c) Provide an explanation for the oversight
- d) Provide a stage 2 complaint response

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

[Case Number: 201907014 – Report issued in March 2020](#)

Mrs X complained that the Health Board had failed to respond to the complaint she made to it on 7 August 2019 in respect of the care and treatment provided to her late daughter.

In considering the complaint, the Ombudsman was concerned that Mrs X had not received a response from the Health Board and as a result of our intervention, by way of settlement, a complaint response was issued to the complainant on 27 March 2020.

[Bron Afon Community Housing Ltd - Housing](#)

[Case Number: 201906725 – Report issued in March 2020](#)

Mrs X complained that the Association had failed to respond to her request for a repair to her roof and had also failed to respond to her formal complaint about the lack of service she had received.

In considering the complaint, the Ombudsman became aware that arrangements were being made to repair the roof, however, he was concerned that Mrs X had not received a formal response to her complaint and therefore contact was made with the Association and it was asked issue a response.

Following intervention from the Ombudsman's office, by way of a settlement, an apology and complaint response was issued to Mrs X on 18 March 2020.

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

[Case Number: 201902369 – Report issued in March 2020](#)

Mrs D complained about Aneurin Bevan University Health Board's overall handling of her complaint, from September 2017 to April 2019 and the delay in providing its response.

Following the decision by the Ombudsman to investigate Mrs D's complaint, the Ombudsman found that it was unacceptable that Mrs D had to wait 18 months for a Putting Things Right complaint response. In addition, it was maladministration on the part of the Health Board that it had not made notes of a meeting with Mrs D and her family.

The Ombudsman also noted that in November 2017, the Health Board became aware that some medical records were missing but Mrs D was not informed until April 2019. These missing records hampered the Health Board's attempts at answering all of Mrs D's concerns. The Ombudsman concluded that the missing records effectively prevented Mrs D from having her complaint about the treatment her late mother received investigated by both the Health Board and the Ombudsman. This amounted to a significant injustice.

To settle the complaint, the Health Board agreed to apologise to Mrs D and make a redress payment of £2,500 for the loss of the medical records and £250 for the time and trouble in bringing her complaint and

the delay in responding. The Health Board also agreed to continue searching for the medical records, to update the Ombudsman every 2 months on its progress and put in place measures to prevent such losses in the future.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

Cardiff Council - Refuse collection. Recycling and waste disposal
Case Number: 201905424 – Report issued in January 2020

Mr X complained that despite being on the assisted lift programme and raising complaints, the Council has failed to ensure that his bins have been regularly collected and returned to the right location. During his enquiries the Ombudsman established that the Council, despite taking action to address his concerns, had failed to ensure that Mr X's bins were collected regularly and returned. The Council agreed to complete the following in settlement of Mr X's complaint by 24 February 2020:

- a) Provide a written apology to Mr X for the failure to collect his bins and return them
- a) Provide reassurance to Mr X that increased monitoring of his route will be undertaken
- b) Undertake an audit of the in-cab technology to show data on whether staff are incorrectly marking bins as being collected.

Caerphilly County Borough Council – Other
Case Number: 201904381 - Report issued in January 2020

Mr X made a complaint, on behalf of himself and other residents, that the Council had failed to deal appropriately with its complaint about a wall, bordering the pavement, which had collapsed and was potentially unsafe.

The Ombudsman noted that the events which had led to the complaint were some years ago and related to liability for the maintenance of the wall. These matters therefore fell outside of the Ombudsman's jurisdiction. However, there were some concerns about the current communication between the Council and the residents to explain the current options and the reasons for the Council's decision. The Council therefore agreed to provide:

- a) A written explanation to the affected residents of the Council's current position (and the powers available to it) in relation to options to resolve the situation under its discretionary powers. This would explain (with reasons) whether it intended to pursue any of the available options. It agreed to provide this by 31 January 2019.
- b) An opportunity to raise and discuss any further queries after the letter was received.
- c) A named point of contact for any future queries about the matter.

Rhondda Cynon Taf County Borough Council - Refuse collection. Recycling and waste disposal
Case Number: 201905648 – Report issued in January 2020

Ms X complained that Rhondda Cynon Taf County Borough Council ("the Council") had not responded to her complaint regarding planning permission for a recycling yard to operate near Ms X's home.

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

- a) To issue its response letter addressing Ms X's concerns by 24 January 2020.

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

[Ceredigion County Council - Noise and other nuisance issues](#)

[Case Number: 201905385 – Report issued in January 2020](#)

Mr M complained about the conduct of officers of Ceredigion County Council (“the Council”) during a pre-arranged visit to his home. Mr M told the Ombudsman that the officers did not introduce themselves properly and were not sufficiently prepared to carry out the purpose of the visit. Mr M said that one of the officers was intimidating towards him but that he did not feel that the Council had afforded sufficient opportunities for him to provide supporting evidence in respect of his concerns.

The Ombudsman did not consider that there were sufficient grounds to investigate Mr M’s complaint further but asked the Council if it would be prepared to provide Mr M with a further opportunity to provide evidence in relation to his allegation of intimidating behaviour. In response, the Council agreed to the following actions:

- a) to invite Mr M, within 2 weeks of the date of this decision letter, to submit within 20 working days copies of the witness statement(s) relating to his complaint about the behavior of Council officers as mentioned in his correspondence with the Ombudsman
- b) to consider and inform Mr M whether or not, in the light of the information contained in the witness statement(s), the Council wishes to re-open its Stage 2 investigation.

The Ombudsman considered that the above actions were reasonable and sufficient to resolve the complaint.

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

[Case Number: 201906649 - Report issued in March 2020](#)

Mr S complained that over approximately a two-year period there have been multiple incidents of non-collection of waste from his property.

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

By 30 April 2020:

- a) Provide a written apology for the failure to collect your waste

Provide reassurance that increased monitoring of your route will be undertaken

[Flintshire County Council - Other](#)

[Case Number: 201906234 - Report issued in March 2020](#)

Mrs O complained about the approach taken by the Council to monitoring the quality of a private water supply at a property she owned. Mrs O said that the Council had not followed relevant regulations and guidance.

The Ombudsman was concerned that the Council had not provided a response to several of Mrs O’s concerns at Stage 2 of its complaints process. In the interest of resolving the complaint, the Council agreed to provide a Stage 2 response to Mrs O within 6 weeks, including references to specific regulations and sections of relevant guidance, to address the following issues:

- a) Why is the water supply at Mrs O’s property subject to annual testing and not testing every 5 years? (Please clarify why the private water supply has been categorised under Regulation 9 and not Regulation 11 of the Private Water Supplies (Wales) Regulations 2017).

- b) On what basis does the Council consider that it is appropriate to carry out annual sampling on the supply at both residences rather than only testing the at the source?
- c) Please clarify whether the Council has classified the 2 supplies at the property under different regulations, and, if so, why.

The Ombudsman considered that the agreed actions represented a reasonable settlement of the complaint.

Housing

Not Upheld

[Wales & West Housing Association - Neighbour disputes and anti-social behaviour](#)
Case Number: 201902313 - Report issued in January 2020

Ms B complained that Wales and West Housing Association was too slow to investigate and address anti-social behaviour at a neighbouring property. Ms B said that as a result she was forced to move to a smaller home. Ms B said that the anti-social behaviour and subsequent move had a significant impact on her health and resulted in the loss of her savings.

The investigation found that the Association took action in line with its anti-social behaviour policy and kept in regular contact with Ms B. The investigation also found that the Association acted quickly to try to re-home Ms B, because it was aware of the impact on her health. However, when an issue arose with the property Ms B was moving to, she accepted another property, from an alternative housing provider, before the Association could resolve the issue or offer an alternative property. The Association also said it would have assisted Ms B to apply for a discretionary housing grant or helped her to move but Ms B did not advise the Association that she was experiencing difficulties. The complaint was not upheld.

Early Resolution or Voluntary Settlement

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

Case Number: 201905174 - Report issued in January 2020

Ms X complained about the service provided by the Council following a flood at her property. During his enquiries the Ombudsman established that the Council had failed to provide a response to Ms X's email and address all aspects of Ms X's complaint. The Council agreed to complete the following in settlement of Ms X's complaint by 24 February 2020:

- a) Provide a written response to Ms X's email of 5 November 2019 and apologise for the delay
- b) Provide a written apology for failing to address all aspects of Ms X's complaint and provide an explanation for this
- c) Provide a written response to Ms X in relation to the aspects of her complaint which have not been addressed.

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

Case Number: 201905761 - Report issued in January 2020

Ms X complained that Trivallis ("the Association") had not completed works to deal with mould and damp issues at Ms X's property as a result of water ingress.

The Association agreed to undertake the following in settlement of Ms X complaint:

By 31 January:

- a) Complete the outstanding works at Ms X's home and recalculate their previous offer of compensation for the delay in completing the works.

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

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

[Case Number: 201904829 - Report issued in January 2020](#)

The complainant was a tenant of the Council. Works undertaken under the Housing Improvement Programme took longer than advised. The complainant complained that the property was uninhabitable during part of the works and that damage was caused to the carpet and furniture by the Contractors. No formal response had been provided to the complaint by the Council.

Mr X, a tenant of the Council, complained about building works undertaken under the Housing Improvement Programme. In particular, Mr X complained that the work took longer than the 3 weeks set out in the Council's tenant information pack, that the property was uninhabitable during the works and that damage was caused to the carpet and furniture by the Contractors.

The Ombudsman contacted the Council as he was concerned that no formal response had been provided to Mr X's complaint by the Council and about the time taken to complete the works.

In settlement of the complaint, the Council agreed to provide Mr X with a formal written response his complaint which was to include an apology for inaccurate information being provided in relation to the proposed timescales for the works, an explanation for any delay in the works being completed, details of the dates the kitchen and bathroom were unavailable for use during works and the Council's policy in respect of this. The Ombudsman considered this to represent an appropriate resolution to the complaint.

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

[Case Number: 201904674 - Report issued in January 2020](#)

Mr X complained that the Housing Association had not taken adequate action to address his complaints about water leaking, from a faulty washing machine in his upstairs neighbour's flat, into his home.

The Ombudsman contacted the Housing Association as he was concerned that the actions it had taken to seek to resolve the matter had not been adequately explained to Mr X. The Ombudsman considered that the Housing Association could have been more proactive in resolving the issue. In settlement of the complaint, the Housing Association agreed to ensure that the faulty washing machine was repaired or replaced and that Mr X was provided with a more full explanation of the actions it had taken thus far to seek to address his complaints. The Ombudsman considered this to represent an appropriate resolution to the complaint.

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

[Case Number: 201906598 – Report issued in February 2020](#)

Mrs X had made a complaint to Carmarthenshire County Council ("the Council") about its failure to provide adequate toilet provisions for her husband when it fitted an adapted toilet in her home. Mrs X complained that despite escalating her complaint, she had not received a stage two response.

In considering the complaint, the Ombudsman was concerned that Mrs X had not received a stage two

response and therefore contact was made with the Council and it was asked to settle on a date to issue the response.

Following intervention from the Ombudsman's office, the stage two response was issued to Mrs X on 26 February 2020.

Powys County Council - Other

Case Number: 201906513 – Report issued in March 2020

Mrs X complained that contractors working for the Council trespassed on her land destroying several trees, badly damaging the lining of her pool and left her garden in a terrible state. Mrs X said that the contractors were hostile, threatening in nature and verbally abusive. Mrs X also complained that the Council had not responded to her recent correspondence.

During his enquiries the Ombudsman established that the Council had failed to respond to Mrs X's recent correspondence. The Council also accepted that there had been wrongdoing by its contractors. In settlement of Mrs X's complaint the Council agreed to the following:

- a) provide an apology to Mrs X for the delay in providing a response to her recent complaint
- b) Provide a formal apology to Mrs X on behalf of the contractors for their wrongdoing
- c) Pay 50% of the cost for the pool liner to Mrs X within 4 weeks upon receipt of a creditable quote
- d) Complete the outstanding repair work to the fence
- e) Complete the outstanding work to the pruning of the trees

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

Case Number: 201905998 – Report issued in March 2020

Mr E complained about the service provided by the Council concerning a repair to a damaged window in his rented property and a re-chargeable repair cost he received.

Mr E said he was in his flat when he heard a noise and found that an exterior pane of a double-glazed unit in a fixed first floor window of his property had been damaged. Mr E said he called the Council and it came out to secure the window as an emergency and then undertook a re-glaze repair a few days later. Mr E said the Council subsequently advised him that the damage was his responsibility and a re-chargeable repair cost would be added to his rent account. Mr E said he did not cause the damage or see how it happened and he should not have been charged for the cost of the repair.

The Ombudsman found that there were errors in the way the Council undertook the window repair and followed its re-chargeable repair process, and that Mr E was not given a proper opportunity to consider his options before the full repair was undertaken or the recharge cost was applied which was a service failure and an injustice to him. To settle the complaint the Council agreed to; apologise to Mr E for the failings identified, to cancel the recharge cost, and to make a payment of £50 to Mr E for his time and trouble in bringing the complaint. The Council also agreed to undertake a review of its re-chargeable repair process to prevent similar errors.

Planning and Building Control

Early Resolution or Voluntary Settlement

Gwynedd Council - Other planning matters

Case Number: 201903535 – Report issued in January 2020

Miss A complained about the Council's response to an incident prior to a pre-arranged meeting with Council officers on 18 February 2019. She also complained about the way the Council have dealt with her, and her family, regarding the Council's Welfare Assessment Report and planning enforcement issues.

The Ombudsman reviewed all the available evidence and decided that the Council's investigation and response to the incident prior to the meeting in February 2019 was reasonable.

The Ombudsman decided that Miss A's concerns about the Welfare Assessment Report and the planning enforcement issues had not been formally responded to by the Council.

Following discussions with the Council it agreed that it would write to Miss A and offer to undertake a fresh assessment of needs to complete a new Welfare Assessment Report, and to formally respond and set out the Council's position on the planning enforcement issues.

[Welsh Government - Planning Inspectorate - Other planning matters](#)

[Case Number: 201906117 – Report issued in February 2020](#)

Mr A complained about the Planning Inspectorate's decision not to award his claim made under the terms of its ex gratia scheme. In its response to Mr A, the Inspectorate said that his claim did not fall within the scope of the Scheme, as he had not demonstrated that 'exceptional circumstances' existed.

The Ombudsman found that the Inspectorate had not been provided with any supporting evidence that exceptional circumstances existed in its consideration of Mr A's claim.

The Ombudsman contacted the Inspectorate and it agreed to:

Within 20 working days:

- a) reconsider, and provide a response to Mr A's claim made under The Planning Inspectorate Claims for Repayment of Additional Costs (Ex Gratia Scheme), taking into consideration the supporting evidence supplied by Mr A, that his claim is made in exceptional circumstances
- b) if Mr A's claim is subsequently rejected, a detailed response is to be provided, specifying precisely why, with reference to the supporting evidence, his claim is not deemed to be made in exceptional circumstances.

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

Roads and Transport

Early Resolution or Voluntary Settlement

[Wrexham County Borough Council - Road maintenance/road building](#)

[Case Number: 201906972 – Report issued in March 2020](#)

Mr X complained that he was unable to drive over a road near his home address as the Council were failing to repair the potholes.

In considering the complaint, the Ombudsman was concerned that whilst the Council had referred to budgetary constraints in respect of the permanent repairs to the road, it had not mentioned when it was going to temporarily fix the potholes.

In settlement of the complaint the Council agreed to undertake temporary repairs on the potholes, by 20

March 2020, weather permitting.

Social Services – Adult

Early Resolution or Voluntary Settlement

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

Case Number: 201906147 – Report issued in March 2020

Mr A complained about the way that the Council conducted Capacity Assessments and made a Best Interests Decision in relation to a family member. He also complained about the lack of communication and their failure to provide a complaint response.

The Ombudsman contacted the Council as he was concerned that no formal response had been provided to Mr A's complaint by the Council and that only limited documentation appeared to have been provided.

In settlement of the complaint, the Council agreed to provide Mr A with copies of relevant assessments, minutes and documentation within 10 working days. The Council further agreed to provide a formal written response to agreed sections of Mr A's complaint and his concerns about Best Interest meeting minutes within 20 working days. The Ombudsman considered this to represent an appropriate resolution to the complaint.

Social Services – Children

Upheld

Betsi Cadwaladr University Health Board - Services for vulnerable adults (eg with learning difficulties, or with mental health issues)

Case Number: 201900898 & 201806745– Report issued in January 2020

Ms A complained about the Council and the Health Board. She said that the Council failed to consider her mother's application for NHS Funded Continuing Care ("CHC") in a timely manner. She said that the decision was pre-judged and therefore failed to consider her mother's needs at the time. Ms A also felt that the process was procedurally incorrect. She also complained about the Council's handling of her complaint. In relation to the Health Board Ms A said that it failed to carry out an assessment of her mother's application for CHC. She said that the Health Board also accepted the Council's decision and therefore failed to independently consider her mother's needs.

The Ombudsman's investigation found that a lack of clarity around the CHC process, including deviations from the CHC process by both the Council and the Health Board, contributed to poor communication and misunderstanding about the process which caused Ms A distress. This part of Ms A's complaint was upheld.

The Ombudsman recommended that both the Council and the Health Board apologise to Ms A. The Council and the Health Board were asked to work collaboratively to ensure that a CHC process is developed, along with clear guidance, about the CHC process so that individuals, relatives and carers were aware of what steps they could take if they remained unhappy with the CHC outcome, as well as to put a mechanism to be put in place for ensuring that planned reviews were undertaken in a timely manner.

Monmouthshire County Council - Safeguarding

Case Number: 201901097 – Report issued in February 2020

Mr L complained about the investigation of his complaint by an independent investigating officer (“IIO”) under Stage 2 of the social services complaints procedure, and Monmouthshire County Council’s (“the Council’s”) response to the resulting report. Mr L claimed the report was unfair, based on unsubstantiated claims and biased against him.

The Ombudsman concluded that the IIO’s report did not evidence an investigation which was impartial and thorough; although the Ombudsman could not conclude that the IIO was actually biased against Mr L, the report gave the impression that they might, consciously or otherwise, have been so. The Council had accepted the IIO’s report without any critical analysis of it.

The Ombudsman upheld the complaint. He recommended that the Council apologise to Mr L, formally withdraw the report and its findings, and issue guidance for use in future by IIOs conducting investigations.

Early Resolution or Voluntary Settlement

Wrexham County Borough Council - Safeguarding

Case Number: 201905643 – Report issued in January 2020

Mr X complained about the actions of Social Services in respect of his daughter. The Council had provided a response to the complaint under stage 1 of the statutory Social Services Complaints Procedure but had not considered the matter in line with stage 2 of that process.

The Ombudsman found that the matter should have been escalated for consideration under the independent stage 2 (formal investigation stage) of the Social Services Complaints Procedure.

The Council therefore agreed to consider the complaint under stage 2 of the Social Services Complaints Procedure within the normal statutory timescales. It agreed to contact Mr X within 5 working days of the date of the decision letter.

Cardiff Council - Safeguarding

Case Number: 201903870 – Report issued in January 2020

Mr X complained about the manner in which the Council had dealt with concerns he had raised about his daughter’s welfare. In particular, he complained that it had not implemented the recommendations of the independent stage 2 investigation and instead, had closed the case.

The Ombudsman found that the Council had reviewed matters as a result of the independent stage 2 investigation, even though Mr X remained unhappy with the resulting action. The Council agreed to provide, by 31 January 2020 a further written response to Mr X to:

- a) Provide reassurance to Mr X about how any future concerns would be dealt with;
- b) Reiterate the apologies in line with the recommendations of the stage 2 report.

Powys County Council - Safeguarding

Case Number: 201905008 – Report issued in January 2020

Mr S complained about the conduct of a social worker towards him and his partner. Mr S also complained about delays in Powys County Council’s (“the Council”) response to their complaint.

The Ombudsman was concerned that the overall length of time taken by the Council to provide a formal response to Mr S’ complaint was excessive. The Ombudsman also considered that the Council had taken too long to provide a formal response to the investigation report.

In response to these concerns, the Council agreed to take the following actions by 17 January 2020:

- a) To provide an apology to Mr S and his partner for the overall length of time taken to respond to their complaint and for the failure to provide a timely formal response to the independent investigation report.
- b) To make a payment of £100 to Mr S in respect of time and trouble in relation to pursuing a final formal response to this complaint.

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

Swansea Council - Other

Case Number: 201905817 – Report issued in February 2020

Miss P complained to the Ombudsman about the response of Swansea Council's ("The Council") social services department to child protection concerns and its handling of her subsequent complaint. The Ombudsman was concerned that it took too long for the Council to complete its response to the complaint. The Ombudsman was also concerned that the Council had not fully implemented the recommendations made by the independent investigation report. In response to the Ombudsman's concerns, the Council agreed to undertake the following actions:

- a) To provide a written apology to Miss P within 2 weeks for delays to the Stage 2 investigation caused by poor record keeping and record management.
- b) To provide written apologies to Miss P within 2 weeks in accordance with recommendations 2, 17 and 23.
- c) To provide within 2 weeks a written response to Miss P's request for data to be expunged from the record.
- d) To invite Miss P within 2 weeks to a meeting with an appropriate officer other than the Principal Safeguarding and Policy Officer to discuss any outstanding concerns regarding the list of recipients of case conference information.
- e) To consider, following the meeting, whether it would be appropriate to write to any agencies to clarify the outcome of social services involvement and to inform Miss P of the outcome of these considerations within 4 weeks of the meeting.

The Ombudsman considered that the above actions represented a reasonable settlement of the complaint.

Powys County Council - Other

Case Number: 201905602 – Report issued in February 2020

Ms X complained about a stage 2 social services investigation conducted on behalf of the Council into issues concerning the care of her step-grandson; she said that the investigation was not thorough enough and she had not received a response or apology following the investigation.

The assessment found that the investigation had been carried out in a reasonable manner. However, there was no evidence that a response had been sent to Ms X following the investigation or that the recommendations made had been fully considered by the Council.

The Council agreed to send its response to the investigation to Ms X within 20 working days to include details of the timescales within which the actions planned to be taken would be completed. The Council also agreed to review the procedure currently in place for social services complaints within 20 working days. If, following that review, the Council considered that the procedure did not comply with the Welsh

Government regulations, it agreed to update it to ensure compliance within the following 3 months.

[Monmouthshire County Council – Safeguarding](#)

[Case Number: 201906217 – Report issued in March 2020](#)

Mrs A complained that Monmouthshire County Council (“the Council”), failed to follow correct procedures whilst undertaking a section 47 investigation, did not provide her with documents and delayed informing her of the outcome. Mrs A further complained about the enquiries made as part of the Stage 2 Complaint Investigation, that some elements of the complaint had not been upheld and that the Council had not undertaken all of the actions identified.

The Ombudsman concluded that the Council had already acknowledged and apologised for elements of maladministration and service failure in its complaint response and that the Stage 2 investigation appeared to have been conducted appropriately. However, the Ombudsman concluded that the actions identified by the Council in its complaint response had not been actioned and the Complainant had not been provided with documents as agreed.

The Council agreed to provide a copy of the Care and Support Plan prepared following Section 47 assessment and provide an apology for the delay in sending the documentation. The Council agreed to provide a written explanation as to why they could not provide minutes of strategy meetings.

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

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

[Case Number: 201806890 - Report issued in March 2020](#)

Miss A complained via her Advocate that the Council had failed to keep her safe when she was placed in emergency bed and breakfast accommodation. She was 17 years old at the time. Additionally, she complained that the Council did not follow health and safety requirements when it came to accommodating vulnerable young people in the bed and breakfast (“B&B”).

My investigation established that the Council had accommodated Miss A under the Social Services Wellbeing Act 2014. The Council confirmed that it had apologised to Miss A particularly in relation to the handling of aspects of her concerns. Additionally, the Council said that it had met and written to Miss A and her Advocate setting out the changes it had introduced as a result of the concerns that Miss A had raised. The Council also confirmed to the Ombudsman's office that its Housing Department now carried out criminal record DBS checks on proprietors/managers of B&B accommodation on its Approved Providers list.

The Ombudsman's investigation found that there had been delays in the Council's complaint handling and that despite the Council's assurances to Miss A and the Ombudsman's office, one aspect of Miss A's complaint had not been addressed at Stage 1 of its complaints procedure.

As part of the settlement agreement, the Council was asked to apologise to Miss A for the shortcomings in complaint handling and make a payment to her of £250 for the inconvenience caused to her. The Council's Housing Department was also asked to provide evidence that it complied with national legislation in relation to emergency B&B accommodation. The Council's Social Services Department was also asked to be mindful of homelessness guidance on emergency B&B for 16 and 17 year olds. In relation to complaint handling, learning lessons and better communication also formed part of the settlement.

Various Other

Early Resolution or Voluntary Settlement

Monmouth Town Council - Poor/No communication or failure to provide information

Case Number: 201905516 – Report issued in January 2020

Mr X complained that Monmouth Town Council (“the Council”) had made an error when it decided to go into private session to discuss an armed forces grant. Mr X had received an email which confirmed that the Council had been misled in believing that the grant should only be considered with the exclusion of the public and press and therefore he should not have been asked to leave the meeting. The Ombudsman considered this to be maladministration on the part of the Council.

Whilst the Responsible Financial Officer (“RFO”) of the Council had apologised to Mr X for the error, in settlement of the complaint, the Council has agreed to complete the following actions:

Within **thirty working days** of the Ombudsman’s decision:

- a) The Chair of Finance & Policy will apologise to Mr X for the error.
- b) The Council will detail to Mr X what measures it has taken to try and reduce the chances of this situation reoccurring.

Ammanford Town Council - Poor/No communication or failure to provide information

Case Number: 201904792 – Report issued in January 2020

Mr B complained to the Ombudsman that Ammanford Town Council (“the Council”) had failed to make documents relating to its meetings available electronically in compliance with its statutory duties under Sections 55 and 57 of the Local Government Wales Act 2013 and Schedule 12 of the Local Government Act 1972. Having considered Mr B’s complaint, the Ombudsman identified that certain documents that should have been available electronically were not available on the Council’s website. In response to the Ombudsman’s concerns, the Council agreed to the following actions:

- a) to ensure that the minutes of the resumed annual general meeting of 17 June 2019 are made available electronically within 4 weeks
- b) to ensure that the Ombudsman’s investigation report (case ref: 201801053) which is referred to in the minutes of the meeting of 17 June 2019 is made available electronically within 4 weeks
- c) to ensure that the next 3 Council meetings formally consider and verify that:
 - i. the minutes of the previous meeting along with any documents referred to in the minutes have been published electronically in accordance with Section 55 of the Local Government Wales Act 2013.
 - ii. that the agenda for the current meeting along with any documents relating to business to be transacted at the meeting was published electronically in accordance with Section 57 of the Local Government Wales Act 2013 and Schedule 12 of the Local Government Act 1972
 - iii. that any necessary corrective action is arranged in order to ensure compliance with the above requirements

The Ombudsman considered that the agreed actions represented a reasonable settlement of the case.

Cardiff Council - Poor/No communication or failure to provide information

Case Number: 201904910 – Report issued in March 2020

Mr D complained to the Ombudsman that Cardiff Council (“the Council”) failed to provide him with adequate notice prior to issuing a summons for non-payment of council tax. Mr D said that he was

unaware that his direct debit had not been transferred to his new bank account and did not receive any emails from the Council in relation to the outstanding balance.

The Ombudsman considered that the Council had followed the relevant regulations and internal procedure and were entitled to issue the summons. Having reviewed the evidence provided by the Council, however, the Ombudsman was concerned that it did not appear that the Council was providing sufficient information to users of the e-billing system to remind them of their responsibilities and the importance of responding to reminder notices.

In response to these concerns, the Council agreed to take the following actions within 6 weeks:

- To make changes to the standard subject headings for emails generated by the e-billing system as agreed with the Ombudsman to emphasise the importance of acting urgently to avoid further liabilities and potential court action
- To include additional information in reminder emails for e-billing users as agreed with the Ombudsman

The Ombudsman considered that the above actions were sufficient to resolve the complaint.

[Natural Resources Wales - Tourism](#)

[Case Number: 201905123 – Report issued in March 2020](#)

Mr X complained that Natural Resources Wales had not provided a response in relation to a complaint he had made on behalf of a co-operative group.

Natural Resources Wales agreed to respond to the complainant within 15 working days of the date of the final letter from this office and to apologise for the delay.