Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

The Ombudsman's Casebook

Issue 42 July – September 2020

Contents

Section 23

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201902686 - Report issued in September 2020

Mrs X was concerned that inadequate eye care was provided to her daughter ("Y") in light of her known self-injurious behaviour (which included hitting herself on the head and face which were known to cause bruising). As a result, Mrs X was concerned that Y's eye injury was not diagnosed sooner. Y has a diagnosis of Atypical Autism, Learning Disability – mild to moderate and mental health difficulties and was, at the time of the events complained about, living in a specialist residential learning disability unit ("the Unit") run by the Health Board.

The Ombudsman found that while Y received good care in terms of planning and delivery to meet her specialised learning disability needs, there were serious shortcomings in the care Y received in June 2018 relating to her eye management. While staff noted concerns in relation to Y's right eye, which required monitoring, there was no evidence that monitoring took place or that these concerns were escalated to clinical staff. When concerns were raised in September about Y's eye, an urgent review was requested and she was taken to the Emergency Eye Unit at a hospital in the area of another health board where she was diagnosed with total retinal detachment and traumatic cataract of the right eye (a cataract is when the lens inside the eye develops cloudy patches).

While it was possible that Y's retinal detachment occurred in June 2018, the Ombudsman was unable to say with any certainty that earlier referral for ophthalmology advice would have resulted in a different outcome for Y. That said, the failure to monitor Y's eye or refer for specialist advice at that time was a service failure; Y did not receive an appropriate level of eye care which was not in line with the requirement to provide fundamentals of care. This caused Y, a vulnerable young adult, an injustice as she was denied the opportunity of a timely referral and clinical review. It was also a considerable injustice to Mrs X as there will always be an element of doubt about whether the outcome could have been different for Y who ultimately lost sight in her right eye.

The Ombudsman also found that communication with Mrs X about Y's eye condition was inadequate and she was not kept updated. This was a serious communication failing as the news of Y's eye condition came as a shock to Mrs X and caused her alarm and distress which was an injustice to her. The Ombudsman **upheld** Mrs X's complaint.

The Ombudsman cannot determine if the action / inaction of a body within his jurisdiction amounts to a breach of human rights. However, he can comment more broadly on whether the Human Rights Act 1998 is engaged. The Ombudsman recognises that individuals in institutional care settings are amongst the most vulnerable in society and so are amongst the most vulnerable to having their human rights compromised. He found that the failings in Y's care engaged her Article 8 rights (a right to respect for one's private and family life) as the Health Board had not sufficiently demonstrated that it had ensured that the needs of an adult with learning disability, such as Y, were sufficiently respected.

The Health Board agreed to the Ombudsman's **recommendations** that, within **1 month** of the date of his report, it should:

a) Provide Mrs X with a written apology for the failings identified.

The Health Board agreed to the Ombudsman's **recommendations** that, within **3 months** of the date of his report, it should:

b) Refer the report to the Board, and the Health Board's Equalities and Human Rights team to

identify:

i. how consideration of human rights can be further embedded into clinical practice
ii. relevant human rights training for Registered Nurses on the Unit (and across the Health Board).

c) Arrange for a copy of this report to be shared and discussed at the next Learning Disabilities Service monthly meeting using this case as a learning event to consider:

iii. adopting the SeeAbility (a charity that provides specialist support, accommodation and eye care help for people with learning disabilities, autism and sight loss) functional vision assessment tool as part of a patient's annual review or in an acute or new scenario
iv. arranging training for staff on the Unit from the Health Board's Ophthalmology Department on the importance of identifying and escalating any concerns relating to possible eye injuries
v. a mechanism for ensuring that patients are accessing regular eye tests / eye health checks in line with the National Autistic Society ("NAS") and SeeAbility advice, and the Learning Disability Annual Health Check (part of the 1000 Lives Improvement, the national improvement services for the NHS in Wales) and NICE Pathways "Learning disabilities and behaviour that challenges overview"
vi. arranging training for Registered Nurses on the Unit to take into account relevant advice, such as the NAS and SeeAbility advice, to inform them of the importance of good eye care for learning disabled and autistic patients, especially where those patients' behaviour includes self-injurious behaviour.

d) Arrange for a copy of this report to be shared and discussed with members of the medical and nursing team involved in Y's care using this case as a learning event to highlight the importance of / remind them:

vii. to follow the Nursing and Midwifery Council's Code around providing fundamental of cares to patients' physical healthcare needs, which includes eye care
viii. to remind the team of the importance of being open and transparent with relatives of patients in reporting patients' injuries and serious incidents to their family
ix. to ensure that the clinical practice of monitoring a patient's physical condition is evidence-based and consistent and that concerns are escalated without delay to senior clinical staff for appropriate action.

e) Provide documentary evidence to show that the recommendations have been carried out within the stipulated timescales.

Health

Upheld

A GP Surgery in the area of Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201904370 – Report issued in July 2020

Mrs A complained that the Surgery missed opportunities to diagnose her husband Mr A's, bladder cancer in 2017 and 2018.

The investigation found that there was a missed opportunity to refer Mr A for further investigation when he attended the Surgery reporting that he had blood in his urine in August 2017. This would have ensured that an appropriate investigation was conducted without delay, in line with guidance, and may have led to an earlier diagnosis of Mr A's bladder cancer. It would also not have relied on Mr A attending a follow-up appointment. The investigation also found that Mr A's clinical records were inadequate and did not fulfil the General Medical Council (GMC) guidelines on good record keeping.

This Ombudsman could not say whether the failing identified would have changed the outcome for Mr A, but the failing identified caused some uncertainty. Had Mr A received an earlier diagnosis he would certainly have been able to receive palliative care, and Mr A and his family could have had time to come to terms with the diagnosis.

The Surgery agreed to apologise to Mrs A, pay Mrs A £1000, remind GPs of the GMC guidelines on record keeping, and complete the implementation of learning points identified during its own review of these events.

Aneurin Bevan University Health Board - Clinical treatment outside hospital

Case Number: 201900841 – Report issued in July 2020

Miss X complained about the delay in the diagnosis of her daughter, Y, with GLUT1 deficiency syndrome (a rare genetic metabolic disorder which affects the nervous system). From the age of 5 weeks Y suffered unresponsive episodes and underwent a series of tests and investigations, but was only diagnosed, following a DNA analysis, in December 2017, when she was aged 4 years 10 months. Y was commenced on the ketogenic diet (a low carbohydrate, high fat diet).

The Ombudsman found that abnormal blood and cerebrospinal fluid tests in July 2013 should have prompted further investigations. Y's symptoms were only slightly atypical of GLUT1 deficiency, such a diagnosis should have been considered and tests carried out to confirm or exclude the possibility. Y had lost out on whatever benefits the ketogenic diet might have provided between 2013 and December 2017, and it was impossible to know whether Y would suffer any long-term ill effects from the delay in diagnosis. The Ombudsman **upheld** the complaint.

The Ombudsman recommended the Health Board apologise to Miss X and pay her £1000 in recognition of the distress caused by the failings and the continuing uncertainty of their effect on Y. He also made recommendations for a systematic method of reviewing test results and sharing the report with its paediatric teams to facilitate learning.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201900908 – Report issued in July 2020

Mr A complained about the poor treatment and management his wife, Mrs A, received following a diagnosis of severe bowel restriction at Ysbyty Glan Clwyd ("the Hospital"). Mr A said that his wife was asked to sign the consent form on the day of the procedure (in fact the day before), which meant that the risks associated with the surgery were not explained to her. As a result, his wife was not in the position to make an informed decision about the procedure and other potential options. Mr A questioned why his wife's rectum was removed, especially given that it would make the reversal of the procedure impossible. He said that they only found out about the removal of his wife's rectum after they complained to the Health Board. Mr A said that his wife has been left in a "terrible situation" with no treatment plan in place to address her ongoing problem. Mr A complained about the Health Board's handling of his complaint which included delays.

The Ombudsman's investigation highlighted concerns about the consent process, which had not been helped by poor documentation. Whilst the consent form that Mrs A signed listed the risks associated with the procedure, there was no record of any discussion with Mrs A, or any detail about the risks being discussed with her or about any alternatives to the proposed surgery. The Ombudsman was clear that a signature to a form which might list risks is not, of itself, indicative of good and informed consent. He said that part of the consent discussion should have included a risk versus benefit exercise. The patient needs to understand, and so be able to decide, if any risk outlined is worth taking while balancing this with their quality of life if opting not to have it. In the absence of documented contemporaneous records of any discussions, the Ombudsman could not conclude that consent was properly informed. He was also concerned that the failures identified may be indicative of wider systemic failings within the Health Board, given the fact that the same administrative and clinical failings around consent were evident for both of the procedures which Mrs A underwent.

The Ombudsman noted that the loss of dignity, self-worth and social isolation that Mrs A now faced as a result of her complications had caused and would continue to cause her a significant injustice. This injustice also extended to her husband as they both had had to adjust to the fact that the plans they had made for their retirement were no longer going to come to fruition. This part of Mr A's complaint was upheld.

The Ombudsman's investigation highlighted significant shortcomings in communication in this case when it came to how information about her condition, the post-operative complications, and her overall management, had been communicated to Mrs A. This has been compounded by the fact that Mrs A was not allocated a clinical specialist nurse key worker. As a result, she had little or no support before and after her surgery. There was also an unacceptable delay in the Second Surgeon reviewing Mrs A following a GP referral. This part of Mr A's complaint was upheld.

Mr A has questioned why his wife's rectum was removed, especially given that it would make the reversal of the procedure impossible. The Ombudsman's investigation noted the reversal surgery could not be carried out due to the post-operative complications and not because the rectum was removed. The Ombudsman did not uphold this aspect Mr A's complaint.

On the issue of complaint handling, the Ombudsman's investigation concluded that given the complexity of the complaint, in the circumstances the delay was not unreasonable. That said, the Ombudsman felt that the Health Board's response could have been more robust in terms of identifying areas where lessons could have been learnt around communication, consent and record keeping and upheld this part of the complaint.

The Ombudsman recommended that the Health Board should:

a) provide Mr and Mrs A with a fulsome written apology for the shortcomings that I have identified in this report
b) pay Mr and Mrs A £250 in recognition of the time and trouble caused by the Health Board's poor handling of their complaint
c) refer Mrs A to a specialist to discuss treatment options and management and in the meantime offer appropriate counselling
d) remind the Colorectal Surgeons of the need to take into account and follow relevant guidance around informed consent, and their professional obligation when it comes to record-keeping to ensure such patient discussions are documented
e) ensure that the Colorectal Surgical Team discuss this case at an appropriate forum as part of reflective and wider learning
f) invite Mr and Mrs A to engage with an equivalent to the Putting Things Right Redress process via

its Legal and Risk Services Team

g) share a copy of this report with the Chair of the Health Board and its Patient Safety and Clinical Governance Group.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201902717 – Report issued in July 2020

Mrs A complained about matters relating to surgery performed by Hywel Dda University Health Board ("the Health Board") to deal with her persistent gastric symptoms. Her complaint centred around her consent to the surgery, whether her discharge after three hospital admissions was safe, and a claim that her past eating disorder had influenced decisions about her post-surgical care (including a delay in her undergoing a reversal of the first surgical procedure). Mrs A also complained about how the Health Board had acted in despatching the police to her home after she had abruptly left hospital following another admission. This event had caused her personally, and her children, significant distress.

The investigation found that the surgery had been adequately explained to Mrs A and that she had several opportunities to ask questions including about the after effects she might suffer. The Ombudsman's professional advisers confirmed that, clinically, Mrs A could safely be discharged following both surgeries as such were often performed on a day admission case basis. However, for one admission in particular, it was found that this was not seemingly well co-ordinated, given her weight risk at the time and there was a failure in communication in respect of her discharge after the reversal surgery. Whilst seemingly fit for discharge, and not inappropriate in itself, Mrs A had been led to believe she would remain in hospital for some days and this was confirmed later by the surgeon who expressed surprise at her discharge. The Ombudsman found that Mrs A's reversal surgery should have been undertaken sooner leading to 3 months of unnecessary discomfort for Mrs A. He upheld these aspects. However, there was no evidence the delay was influenced by attributing Mrs A's ongoing symptoms to her past eating disorder.

The Ombudsman found that the police attendance at Mrs A's home was inappropriate, based on a wrong interpretation of the powers set out in the Mental Health Act 1983 (as revised). He also found that this engaged human rights considerations; particularly Mrs A and her family's Article 8 rights, impacting on their private and family life and causing them great distress.

The Ombudsman made the following recommendations, which the Health Board agreed to implement:

a) to apologise to Mrs A and her family
b) make a redress payment of £1,000
c) the surgical team to reflect on the issues raised in Mrs A's case
d) all junior doctors in the hospital's surgical team to undergo training on the Mental Health Act's provisions as well as human rights issues.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201804550 – Report issued in July 2020

Mr A complained that the Health Board failed to give him appropriate information about the illness and prognosis of his wife, Mrs A, during her hospital admissions and at the point of discharge, in September and October 2017. He also complained that the Health Board failed to arrange appropriate aftercare services for Mr & Mrs A, when she was discharged in September and October 2017.

The Ombudsman found that there were records of discussions with Mr A about the severity of Mrs A's illness during both admissions, although the Health Board could not predict exactly how long Mrs A had to live. He did not uphold this part of Mr A's complaint. Mr & Mrs A declined carers prior to Mrs A's discharge home; however, although the Health Board referred Mrs A to the Rapid Response Team (which

provides short-term intervention), it did not check that Mrs A's previous support from a charity providing palliative care was ongoing (it was not). The Rapid Response Team discharged Mrs A from its service when it referred Mrs A back to the charity, but there was a period of 12 days when Mr & Mrs A did not receive care and support while Mrs A's condition deteriorated. The co-ordination of continued aftercare services was not appropriate, and the Ombudsman upheld that part of Mr A's complaint.

The Ombudsman made recommendations for an apology to Mr A, and for the report to be shared with clinicians involved in Mrs A's care in order to facilitate reflection and learning.

A GP Practice in the area of Hywel Dda University Health Board ("the First Practice") & a GP Practice in the area of Swansea Bay University Health Board ("the Second Practice")

Case Number: 201902428 & 201901616– Report issued in July 2020

The investigation considered the care and treatment provided to Mr Y during a telephone triage consultation with a GP ("the GP") at the Second Practice in November 2018, and whether there was a failure to diagnose a heart condition diagnosed later that day when Mr Y attended hospital.

The Ombudsman found some shortcomings in the care Mr Y received from the GP which did not accord with GMC guidance (history-taking, record-keeping, recording of safety-netting advice, lack of diagnosis, and inappropriate prescription of inhaler, although this prescription was extremely unlikely to have had a negative impact on Mr Y's cardiac condition so there was no injustice in prescribing it). That said, had the GP diagnosed a possible cardiac condition, Mr Y would have still required the same treatment. The impact of these shortcomings was limited but caused an injustice to the extent of loss of confidence in the GP and the potential for earlier investigation of his symptoms. The complaint was upheld to this limited extent. The Ombudsman recommended an apology and reflection and learning for the GP.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201805275 – Report issued in July 2020

Mrs G complained about the care and treatment provided to her late husband, Mr G concerning cardiology services and 2 admissions to the Emergency Department ("ED") in January 2018. Specifically, Mrs G said Mr G should not have been discharged from the cardiology service in 2016 and, following his first admission to the ED in January 2018 Mr G should have been referred to a cardiologist. Mrs G said following Mr G's cardiac arrest and second ED admission in January 2018, the ED should have done more to save him.

The Ombudsman found Mr G's discharge in 2016 was appropriate and this aspect of the complaint was not upheld. The Ombudsman found that whilst Mr G's discharge from the ED following his first admission in 2018 was acceptable, he was not referred to the cardiology service and this was a service failure. The Ombudsman found that whilst the overall care and treatment provided to Mr G following his second admission in 2018 was appropriate, Mrs G and the family were not given enough time to come to terms with the situation or question his outlook and this was an injustice. Therefore, these elements of the complaint were upheld to a limited extent.

The Health Board agreed within 6 weeks to apologise to Mrs G for the failings identified, to explain why Mr G was not referred to the cardiology service and to share the report with relevant staff for critical reflection. It also agreed within 3 months to include Mr G in its mortality and morbidity meetings and within 6 months to review its guidelines for management of patients with syncope and the inpatient /outpatient ED pathway into cardiology.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201902169 – Report issued in July 2020

Ms A's concerns included her care and management by Hywel Dda University Health Board ("the Health Board") at Withybush General Hospital and Glangwili General Hospital during her second pregnancy. This included a failure to identify that she was pregnant with twins following her scan on 28 March 2018. Ms A

also expressed concerns that the Midwife, during Ms A's 16 week antenatal appointment with her, had not taken appropriate action despite the absence of a foetal heartbeat. Ms A also complained about the Health Board's complaint handling and the robustness of its complaint response.

The Ombudsman concluded that there was no evidence to suggest that the scan on 28 March showed a second pregnancy. As there were no shortcomings in this aspect of Ms A's care and management the Ombudsman took the view that there was no reason to suppose that staff interactions with Ms A at the time could have been any different. This aspect of Ms A's complaint was not upheld.

The Ombudsman was satisfied that monitoring a foetal heart rate at the 16 week scan was outside the recommended guideline. That said, once it was identified that the heart rate was absent, there should have been an appropriate scan referral to establish the position regarding the foetal heart rate. Additionally, Ms A should have been seen by an obstetrician. The Ombudsman concluded that whilst what had happened was a failing, sadly in Ms A's case the outcome would not have changed. Nevertheless, the Ombudsman found that the shortcoming in Ms A's care had caused her distress and this was an injustice to her. He upheld this aspect of Ms A's complaint. The Ombudsman was pleased to note that the Health Board had taken steps to remind its midwifery staff of best practice in this area. Had it not done so this would have formed part of the Ombudsman's recommendations.

In relation to the Health Board's complaint handling, the Ombudsman found that whilst there was a delay in the Health Board responding to Ms A's complaint, this was attributable to it seeking an independent view on the scans. The Ombudsman concluded that the delay was not unreasonable and the complaint response was comprehensive and robust. He therefore did not uphold this aspect of Ms A's complaint. The Ombudsman recommended that the Health Board apologises to Ms A for the failing identified.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905116 – Report issued in July 2020

On 22 July 2019, when Miss X was 20 weeks and 4 days pregnant, she was admitted to Wrexham Maelor Hospital ("the Hospital") because of persistent vaginal bleedings and abdominal tightening. It was explained that the source of the bleeding was possibly because of cervical erosion (inflammation of the cervical cells) and placental abruption (when the placenta separates from the uterus before the baby is born). Miss X was discharged on 23 July. On 24 July Miss X attended the Hospital as her waters had broken (preterm premature rupture of membranes – the breaking down of the amniotic sac before 37 weeks of pregnancy). A scan showed that most of the fluid around the baby was lost with evidence of bleeding in the pregnancy sac. Miss X was discharged on 29 July and sadly, her baby died on 1 August. Miss X complained about her discharges on 23 and 29 July.

The Ombudsman found that the discharges on 23 and 29 July were appropriate. He found that the clinical records were unclear whether Miss X was aware of the risks, she should have been additionally counselled that the source of infection was unlikely to be treated with antibiotics and the microbiology investigations should have been reviewed. These were service failures that led to an injustice for Miss X as she may not have been fully aware of the risk of miscarriage. The Ombudsman partly upheld the complaint.

The Health Board agreed to implement the Ombudsman's recommendations within 1 month to apologise to Miss X for the failings, to remind staff the importance of documenting communication with patients and that microbiology investigations should be reviewed during admission.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201900566 – Report issued in July 2020

Ms K complained that Aneurin Bevan University Health Board failed to take appropriate follow-up action after her grandfather Mr L, underwent an X-ray in November 2017 that showed some "shadowing" but which the Health Board reported as normal. Mr L underwent a further X-ray in April 2018 and was

subsequently diagnosed with lung cancer 2 months later. Mr L sadly died in September. Ms K said that had the Health Board identified her grandfather's cancer sooner, more could have been done for him. The Ombudsman found that the Health Board should have identified Mr L's cancer sooner following his X-ray in November 2017. This amounted to a service failure and was an injustice to Mr L and his family. The Ombudsman upheld this part of the complaint.

However, the Ombudsman concluded that whilst Mr L's cancer should have been diagnosed sooner, Mr L's treatment options were very limited due to him having other significant health issues. Therefore, there was little more that could have been done for him. The Ombudsman did not uphold this part of the complaint.

The Ombudsman recommended that the Health Board apologise to Ms K and share his report with the Radiology department to aid future learning. The Health Board agreed to the Ombudsman's recommendations.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201901082 – Report issued in July 2020

Mr X made a complaint about the care and treatment his father, Mr Y, received from the Health Board in August 2017. In particular, Mr X complained that the level of monitoring and the nursing responses provided to Mr Y were not of a reasonable standard, that it was not reasonable to administer morphine in the amount given to Mr Y, that nursing staff on the Ward did not appropriately administer Cardiopulmonary Resuscitation ("CPR") to Mr Y, and that Mr X's complaint was not handled properly or in a timely manner.

The investigation found that the level of monitoring and nursing responses given to Mr Y were reasonable. It did not uphold this complaint, and did not uphold Mr X's complaint that it was not reasonable to administer morphine to Mr Y, who was considered to be at the end of his life. Unfortunately, due to conflicting evidence it was not possible to determine exactly how CPR was administered to Mr Y; however, the investigation determined that any delay in beginning CPR could only have been relatively short. The complaint was not upheld, as the investigation found that Mr Y was highly unlikely to have benefitted from CPR even if it had been delivered immediately. The investigation upheld Mr X's complaint that his complaint to the Health Board was not handled in a timely manner.

The Health Board agreed to apologise to Mr X for the delay in handling his complaint, and for the inconvenience in requiring Mr X to attend a second meeting, within 2 months.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201903936 – Report issued in July 2020

Mr B complained about the care provided to his wife Mrs B, during her admission to hospital between 14 and 15 February **2018** and following her diagnosis of Acute Coronary Syndrome ("ACS"), a term used to describe a range of conditions associated with sudden, reduced blood flow to the heart. Mr B complained that the Health Board failed to identify Mrs B's worsening condition and give her appropriate care and treatment based upon her symptoms, and failed to give Mrs B her medication for diabetes or adequately monitor her condition before she died on 15 February.

The Ombudsman found that Mrs B's care was not appropriate, documentation was unsatisfactory, and assessments were not fully completed. Mrs B was inappropriately left in the care of a junior doctor and she was not reviewed by a senior clinician even though referrals were made to 2 senior clinicians. Transfer to a Cardiology ward should have been considered and she should have received the appropriate treatment for ACS. The Ombudsman received advice that Mrs B was at high risk of death based upon her condition. Whilst it is not possible to be certain that appropriate treatment would have changed the outcome, it was unreasonable of the Health Board to say that it would not have made any difference. This uncertainty was an injustice to Mrs B's family and the complaint was upheld.

The Ombudsman also found that the Health Board failed to treat Mrs B's diabetes. The Ombudsman was advised that this failing was unlikely to have made a difference to the outcome for Mrs B. However, this was because Mrs B was already so unwell with untreated ACS and not because the care for diabetes was within the bounds of acceptable practice. The Ombudsman found that there was an injustice to Mr B in knowing that the Health Board did not provide appropriate care; he upheld this complaint.

The Health Board had already made changes to its practice because of this complaint. It accepted the findings of the investigation and agreed to implement a number of recommendations. The Health Board agreed to, within 1 month, apologise to Mr B and his family and provide the Ombudsman with details of the action it has taken in respect of diabetic patient care, including the introduction of a diabetes champion, pre-assessment plans and training. Within 3 months the Health Board agreed to provide evidence that each member of clinical and nursing staff involved in Mrs B's care has reflected upon the findings of this report with their manager or supervisor, and satisfy itself that the clinicians involved have taken appropriate action to address the concerns identified in respect of inadequate record keeping and completion of assessment documents.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 202001284 - Report issued in August 2020

Mrs A complained about the standard of care provided to her sister by the Welsh Ambulance Services NHS Trust ("the Trust") when it attended to her on 4 separate occasions between 4 and 6 April 2019. Mrs A said that she submitted a response to the Trust but she was not satisfied with the response it provided on 11 May 2020.

The Ombudsman took into account that as part of the Trust's investigation, it had already provided a reasonable explanation to concerns raised by Mrs A about 3 of its 4 attendances. It had carried out relevant action to address and/or resolve matters, which included an apology for the failings identified and an explanation of action being taken to improve its service. The Ombudsman also noted that there were concerns raised with the Trust about a fourth attendance that had not been addressed adequately.

The Ombudsman contacted the Trust and it agreed to - within 30 working days:

a) Provide a further comprehensive written response to Mrs A, addressing her concerns about the decision taken by the Trust not to admit her sister to hospital on 5 April 2019. The response should include full details of the assessment carried out, including the details of conversations that took place with any other medical professional(s) which contributed to the decision being reached not to admit her sister to hospital.

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

Welsh Ambulance Services NHS Trust - Ambulance Services

Case Number: 201905343 - Report issued in August 2020

Mrs X complained on behalf of the family of the late Mrs Y that the Trust failed to properly prioritise telephone calls, failed to follow-up on an unsuccessful telephone triage, handled her complaint poorly, and failed to provide her with requested information.

The Ombudsman found the Trust's own investigation had identified that a call it received on Mrs Y's behalf was incorrectly prioritised. The call should have received an emergency response within 8 minutes. The investigation found that all earlier calls had been categorised correctly. This element of the complaint was **upheld** to the limited extent that Mrs Y's family had not yet received an apology from the Trust for the failing it had identified in its own investigation.

The Ombudsman found that the Trust followed the correct procedure when it was unable to successfully assess Mrs Y's condition via telephone, and the limited assessment which was completed resulted in Mrs Y's incident receiving a higher priority. This complaint was **not upheld**.

The Ombudsman **upheld** Mrs X's complaint about the Trust's complaint handling as there were issues and miscommunication related to Mrs X's request for information which could have been resolved at an earlier stage of the Trust's investigation. This led to a failure to appropriately manage Mrs X's expectations about the disclosure of information. The Ombudsman did **not uphold** Mrs X's complaint about a failure to disclose information to her as she had not provided evidence to the Trust that she was entitled to the information requested.

The Trust agreed (within 1 month) to apologise to Mrs Y's family, to apologise to Mrs X for the complaint handling failings, and to write to Mrs X to explain how she may obtain the information she requested.

A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 201903599 - Report issued in August 2020

Mrs X complained about the care and treatment her late daughter Ms Y, received from the Practice. Mrs X complained that:

a) when Ms Y attended the Practice in December **2015**, complaining of a breast lump and a dent in her thigh, she was referred to the Breast Clinic but the problem with her thigh was brushed aside and not investigated;

b) that when Ms Y attended the Practice between October and December **2017**, complaining of severe dizziness and ear problems, no investigations were requested despite Ms Y's concern about a swollen lymph node;

c) about the management of Ms Y's hip/leg pain;

d) that the respective GPs who reviewed Ms Y did not consider the relevance of her raised calcium levels.

The Ombudsman found that there were no investigations/referrals that should have been performed/made regarding the dent in Ms Y's thigh. He found that the conduct of the respective GPs between October and December 2017 was clinically appropriate. The lack of examination undertaken by the Third GP (who is no longer employed at the Practice) when Ms Y presented with hip/leg pain amounted to a service failure. If an examination had been carried out, it may or may not have led to a request for an X-ray and this would have revealed a possible metastasis (secondary cancer) in the femur (thigh bone) requiring further investigation. If an X-ray had been undertaken it would have resulted in Ms Y being diagnosed with metastasis of the femur up to 41 days earlier. This uncertainty amounted to an injustice and therefore this aspect of the complaint was upheld. He found that the respective GPs' actions following a rise in Ms Y's calcium levels was appropriate.

The Practice agreed to apologise to Ms X for the failures identified, reflect on the failing and discuss the case in a Significant Event Analysis and ensure that a copy of the report be sent to the Third GP and draw her attention to the relevant paragraphs of the report.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201901621 - Report issued in August 2020

Mr X complained about the care and treatment that his late wife (Mrs X) received from Swansea Bay University Health Board ("the Health Board"). Mr X complained that there had been a failure to; appropriately monitor Mrs X's high potassium levels, obtain consent for dialysis (which included communicating with him) and carry the procedure out in an appropriate setting, and diagnose and

respond to Mrs X's sepsis. In addition, Mr X complained that the complaint response was inadequate, and that it had not, along with Mrs X's clinical records, been provided to him in a timely manner.

The investigation found that Mrs X's high potassium levels were quickly recognised and were appropriately monitored and treated. There was a service failure regarding the obtaining of consent for dialysis, however there was no injustice caused, as if the procedure had not been carried out it was likely that Mrs X would have died. The investigation found that the ward was an appropriate setting for dialysis. The investigation found that the NICE Guidelines on Sepsis were not followed and this amounted to inappropriate clinical practice, however there was no injustice caused as Mrs X had a very poor prognosis and there was no evidence that any change in management would have prevented her death. The investigation found that the Health Board failed to adhere to the Regulations and associated Guidance when dealing with Mr X's complaint, it did not keep him updated as to the status of the complaint and the content of the response was lacking in detail. In addition, there was an unacceptable delay in the sending out of Mrs X's clinical records. This aspect of the complaint was therefore upheld. The Health Board agreed to apologise to Mr X for the complaint handling failures, provide him with a redress payment of £250.00 and provide training to its Quality and Safety Team around complaint handling.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905901 - Report issued in August 2020

Mr F complained about the care and treatment afforded to his late wife, Mrs F, by Betsi Cadwaladr University Health Board ("the Health Board"). Mr F said that the Health Board failed to provide Mrs F with adequate nursing care and, specifically, failed to appropriately manage Mrs F's nutritional needs. Mr F also said that the Health Board failed to adequately communicate with him regarding Mrs F's care and treatment.

The Ombudsman's investigation found that Mrs F received appropriate nursing care, in line with relevant clinical guidance. The investigation also found that the management of Mrs F's nutritional needs was appropriate. As a result, the Ombudsman did not uphold this aspect of Mr F's complaint.

The investigation also found that the completion of the DNACPR form was not in line with relevant guidance and fell below an acceptable clinical standard. In addition, the investigation found that the clinicians' discussions with Mr F about Mrs F's diagnosis, plan of management and prognosis should have been more frequent. The Ombudsman concluded that this caused Mr F an injustice as it contributed to Mr F being unable to understand and accept the situation which caused him anxiety and distress. The Ombudsman recommended that the Health Board apologise to Mr F and pay him £500 for the failings identified. He also recommended that the Health Board should share the report with the relevant clinicians for critical reflection and remind relevant staff of the importance of clear communication with patients and families. Finally, he recommended that the Health Board remind senior clinicians that DNACPR forms should be completed and signed in line with the All Wales DNACPR policy.

Swansea Bay University Health Board and a GP Practice within the area of Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201807750 & 201807994 - Report issued in August 2020

Mr A complained about the care provided to his son, Mr C, by the District Nursing Team and a GP Practice within the area of Swansea Bay University Health Board, which was previously known as Abertawe Bro Morgannwg University Health Board. Mr A also complained that the Health Board failed to monitor and treat Mr C's abnormal liver function appropriately and to communicate effectively with other clinicians involved in Mr C's care. The events took place between October 2017 and April 2018.

The Ombudsman found that inadequate record keeping by the District Nursing Team meant that there was no evidence to demonstrate that adequate wound care was provided to Mr C. He found that the GP Practice appropriately monitored Mr C and referred him to the Gastroenterology Department to

investigate Mr C's abnormal liver function. However, he **suggested** that the GP Practice should remind its GPs of the importance of ensuring that all referrals present the whole clinical picture, especially where test results have varied over time.

There were missed opportunities when Mr C attended the Emergency Department to take action to expedite the investigation of his abnormal liver function. On 2 occasions Mr C should have been reviewed urgently by a specialist before he was discharged. The Ombudsman considered that 6 months was an excessive time for Mr C to wait to be reviewed by the Gastroenterology Department, given the urgency of his referral and his blood test results, although the Health Board had taken action to improve capacity within the service.

The Ombudsman also found that, when Mr C was reviewed, the Gastroenterologist failed to recognise the severity of Mr C's condition. Additionally, the Gastroenterologist failed to seek a formal review of Mr C's eligibility for a liver transplant. Consequently, Mr C and his family were unaware of the terminal nature of his liver failure until he was admitted to hospital in April 2018, where Mr C died. Whilst the Ombudsman concluded that it was unlikely that Mr C would have been eligible for a liver transplant, this failure meant that neither Mr C nor his family were given any opportunity to prepare for the sad fact that it was likely to end Mr C's life or to plan his end-of-life care. These elements of Mr A's complaints were therefore **upheld**.

The Ombudsman recommended that, within 1 month of the date of his report, the Health Board should remind relevant staff of appropriate guidance and standards, including those on record keeping and criteria for specialist referrals and hospital admissions. He also recommended that the Health Board offer an apology and £1000 redress to Mr A in recognition of the length of time the family went without the important information about the terminal nature of Mr C's liver disease, and therefore the amount of time that they lost.

The Ombudsman also recommended that the doctors involved in this case should reflect on the Ombudsman's findings and conclusions within 4 months of the date of this report. Finally, he recommended that, within 8 months, the Health Board should conduct audits of its District Nursing records, for compliance with relevant standards, and of Gastroenterology referrals, to ensuring appropraite prioritisation and timescales before appointments are offered, and take action to address any further shortcomings.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201901573 - Report issued in August 2020

Mrs B complained about the care and treatment she received at Nevill Hall Hospital ("NHH") following a fall in which she fractured her hip. Mrs B complained that:

1) Clinicians failed to obtain a copy of an MRI scan of her hip from a hospital in England ("the Second Hospital") before carrying out a Dynamic Hip Screw ("DHS") implant operation.
2) Within weeks, she required a second operation - a Total Hip Replacement ("THR") - at the Second Hospital. The DHS operation was therefore clinically inappropriate.
3) A staff member insensitively told her that, as she lived in England, she was not eligible to receive treatment from the NHS in Wales.
4) Aneurin Bevan University Health Board's ("the Health Board's") provision of a response to the complaint was excessively protracted and deficient.

The Ombudsman upheld complaints 3 and 4. With regard to complaint 1, he determined that NHH clinicians should have made some attempt to obtain the MRI scan as a matter of good practice. However, he concluded that there was no adverse clinical consequence to their failure to do so. He also agreed

that the staff member behaved unprofessionally but considered that the apology offered for this by the Health Board was a sufficient and reasonable response. He found that the Health Board's production of its complaint response was excessively delayed.

With regard to complaint 2, the Ombudsman could not reach a definitive finding. In cases of fractured neck of femur, NICE Clinical Guidance advocates a THR operation. However, the exception to this is when the fracture occurs at the base of the neck of the femur. Whilst the surgeons documented that this was the case (following radiological screening during the operation), the X-rays demonstrating this were not retained. However, the Ombudsman found no evidence to support Mrs B's view that she had received the "wrong operation".

The Ombudsman was concerned that the surgical options and their consequences were not fully explained to Mrs B during the pre-operative consenting process. As such, she was not informed that the DHS surgery would not remove the need for a THR in due course. The Ombudsman considered this to be a breach of GMC Guidance governing the consenting process and he upheld this point.

The Ombudsman recommended that the Health Board should apologise to Mrs B for these failings and make a payment to her of £500 in recognition of the avoidable distress and inconvenience that she incurred in pursuing and escalating her complaint. He also recommended that the report should be shared with the orthopaedic team at NHH and that they should reflect upon:

- The NICE Guidance for the treatment of neck of femur fractures and the importance of clearly documenting clinical reasons for departing from it.
- The requirements of conducting and recording the consent to surgery process and / or other pre-operative discussions with patients in accordance with the (updated) provisions of GMC Guidance.

Finally, he recommended that the Concerns Team should be reminded of the requirement to ensure that holding letters sent to complainants accurately explain the reasons for delays or disruptions to the complaint investigation process. The Health Board agreed to implement these recommendations.

Aneurin Bevan University Health Board - Appointments/admissions/discharge and transfer procedures
Case Number: 201902084 - Report issued in August 2020

Mrs X complained on behalf of her son, Y, that ISCAN, the single point of access for children with additional needs at Aneurin Bevan University Health Board ("the Health Board"), failed to provide appropriate care and treatment for Y's additional needs, and failed to make appropriate referrals to services in relation to Y's additional needs from July 2018 to October 2019.

The investigation found that it was reasonable for ISCAN not to make any referrals in relation to Y on the first 2 occasions when his needs were considered, but that it was not reasonable on the third occasion. This was because that referral had identified various needs, including a need for OT and SLT, but was closed without addressing these. The failure caused Y an injustice because assistance for his needs was delayed. The complaint was **partly upheld** in relation to the third referral only. Mrs X's complaint that the Health Board did not provide appropriate care and treatment for Y's additional needs was **upheld** because it did not appear that the Health Board had provided any care or treatment for Y's additional needs until after his genetic condition was diagnosed in October 2019, despite the first referral to ISCAN being made over a year earlier. By this time, Y had been out of education for over 12 months and had been considered by ISCAN on 3 separate occasions.

The Health Board agreed to apologise to Mrs X and Y, and to reimburse them for the costs they incurred in obtaining a private Speech and Language Therapy report for Y, within 3 months. The Health Board also agreed to confirm the current support available to Y within 3 months. The Health Board also agreed that within 6 months, it would undertake an audit of ISCAN outcome reports to check that they clearly

explained why decisions had been made, what services or agencies would best support the child's needs, and what the on-going plan for the child was.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201901025 - Report issued in August 2020

Mrs X complained that her adult son, Mr Y, was not properly assessed in relation to discharging him from detention under section 2 of the Mental Health Act 1983, that Mr Y was transferred inappropriately from a Psychiatric Hospital to a General Hospital, that communication was poor and that Mr Y did not receive appropriate care after being discharged from detention. Mrs X also complained that her complaint was not handled properly by the Health Board

The investigation found that Mr Y had been assessed by a Consultant Psychiatrist before he was discharged from detention under section 2, and was assessed by 2 General Physicians before he was discharged from hospital. It also determined that the transfer of Mr Y from the Psychiatric Hospital to the General Hospital was appropriate, and therefore **did not uphold** the first 2 aspects of Mrs X's complaint. The investigation learned that there was confusion between staff about why Mr Y had been transferred to the General Hospital, and whether he was to be transferred back to the Psychiatric Hospital prior to his discharge, and about whether Mr Y had been discharged from detention. This caused the family and Mr Y an injustice because they were left without answers at a very stressful time. The complaint that Mr Y did not receive appropriate care following his discharge was also **upheld** because Mr Y did not receive follow up care in line with good practice, even though his family continued to express concerns about his health. Finally, Mrs Y's complaint that her concerns were not addressed appropriately by the Health Board was **upheld** due to delays in communicating with her and conflicting information in the responses.

The Ombudsman **recommended** that within 1 month the Health Board should apologise to Mrs X and Mr Y, and that within 4 months it should amend its Guidance on follow up after discharge, and remind staff of guidance on disclosing information to relatives of detained patients.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201807859 - Report issued in August 2020

Mrs A complained about the care and treatment her late son Mr B, received at Glangwili Hospital. Specifically, Mrs A said that there had been a failure to investigate Mr B's complaints of chest pain and appropriately manage his complaints of pain.

The investigation found that whilst there had been missed opportunities to diagnose Mr B's aortic dissection, it was not possible to state whether the sad outcome would have been any different, if those opportunities had been taken.

The investigation also found that, having declined ibuprofen because underlying conditions meant that it was contra-indicated, Mr B was not offered any alternative pain medication. The complaint was upheld. It was recommended that the Health Board apologise to Mrs A for the failings. It was also recommended that the Health Board provide training to all ED nursing staff on the administration of appropriate pain medication and the THINK AORTA campaign. It was recommended that the Health Board undertake a full significant event investigation into the matter and share any lessons learned. Finally, it was recommended that the content of the report be discussed with the relevant clinicians during their next supervision session.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201904055 - Report issued in September 2020

Mrs J complained about the care her late father, Mr R, received at Wrexham Maelor Hospital, in particular:

1) management of Mr R's nasogastric tube

2) the attitude of members of staff when family members raised concerns
3) inadequate attention to skin care, resulting in the development of pressure sores
4) management of Mr R's medication
5) inadequate monitoring of Mr R, in particular the failure to remove an X-ray board when he returned to the ward.

Mrs J also complained about the way in which Betsi Cadwaladr University Health Board ("the Health Board") handled her complaint.

The Ombudsman did not identify any failings in the management of Mr R's nasogastric tube, or in the administration of his medication. There was no evidence staff had behaved inappropriately, and family members' concerns were taken seriously. The Ombudsman could not conclude the failure to remove the X-ray board was any more than a momentary oversight. He did not uphold complaints a) b) d) or e) above. Some nursing records, in particular charts and assessments, were missing, and the Ombudsman could not evaluate the skin care Mr R received; however, the absence of such records amounted to maladministration and he upheld complaint c). He also upheld the complaint about complaint handling, to the extent only that the Health Board did not provide Mrs J with updates throughout the investigation.

The Ombudsman made recommendations for an apology to Mrs J, and for complaint handlers to be reminded to keep complainants up-to-date with the progress of investigations. He also required the Health Board to inform him of the actions it had taken to implement recommendations contained in his thematic report (issued in 2019) on lost records.

Swansea Bay University Health Board & Cwm Taf Morgannwg University Health Board - Clinical treatment outside hospital & Clinical treatment outside hospital
Case Number: 201906313 & 201900478 - Report issued in September 2020

Mrs B complained about the care and treatment her late mother, Mrs P, received from the Health Boards after she developed endometrial cancer (cancer of the lining of the womb) in 2014.

The Ombudsman found that while the First Health Board did not provide cancer surgery to Mrs P within expected timeframes, there was no evidence that the delay caused harm to her. The Ombudsman partially upheld Mrs B's complaint that the First Health Board did not provide appropriate follow up care to Mrs P. The First Health Board's failure to pass a Gynae-Oncology referral to the Second Health Board was found to have delayed diagnosis of the recurrent cancer which sadly led to Mrs P's death. While earlier diagnosis would not have prevented this outcome, the Ombudsman found that it would have allowed effective pain control to be given to Mrs P up to 2 months sooner, which was an injustice. The Ombudsman upheld Mrs B's complaint against the Second Health Board relating to pain and distress caused to Mrs P as a result of failed attempts to remove a pigtail drain. The Ombudsman found that the Second Health Board's response to Mrs B's complaint did not reflect the seriousness of the pain and distress caused to Mrs P during the incident. It had also failed to properly investigate Mrs B's allegations that Mrs P's requests for the procedure to be stopped were ignored. The Ombudsman was satisfied that there was no failure on the part of the Second Health Board to diagnose or treat Mrs P's sepsis in a timely and appropriate manner.

The Ombudsman recommended that the First Health Board should within 1 month, apologise to Mrs B and make a payment of £500 to her in respect of the impact of the failure to ensure that the Gynae-Oncology referral was received. In respect of the Second Health Board, the Ombudsman recommended that it should within 1 month, apologise and make a payment of £1000 to Mrs B for the pain and distress caused to Mrs P by the failure to remove the pigtail drain properly and for the failure to carry out an appropriate investigation into the allegations of withdrawal of consent. The Ombudsman recommended that the Second Health Board should within 1 month, ensure that the Staff Nurse involved discusses the

contents of the report with a manager for the purposes of continual professional development. The Ombudsman also recommended that the handover of written instructions for the use of drain devices on wards should be recorded in the patient notes and that all staff at the Princess of Wales Hospital, Bridgend should be reminded of the importance of ensuring that instructions have been fully understood when they delegate clinical tasks to colleagues. Finally the Ombudsman recommended that the Second Health Board should within 3 months, introduce mandatory training for all clinical staff on how to recognise and respond appropriately to potential withdrawal of consent.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201903797 - Report issued in September 2020

Mr G complained on behalf of his father-in-law, Mr E, about the care and treatment provided by Cardiff and Vale University Health Board ("the Health Board") to his late mother-in-law, Mrs E, concerning an aneurysm, and the way the Health Board communicated with the family about her condition.

The Ombudsman found that the care and treatment provided to Mrs E was acceptable and her situation was managed appropriately. This element of the complaint was **not upheld**. However, the Ombudsman also found that during the Health Board's interactions with Mrs E and her family about her condition and a proposed procedure, it failed to communicate the overall risks associated with the treatment and future medication requirements, and the risks and benefits concerning alternative options. This left doubt for Mrs E's family as to whether she might have made a different choice about her treatment and was an injustice as they were left with an uncertainty about whether anything else could have been done to help her. This element of Mr G's complaint was therefore **upheld**.

The Health Board agreed (within 6 weeks of the Ombudsman's decision) to apologise to Mrs E's family for the failings identified, and to take steps to ensure neurovascular MDT outcomes state whether an aneurysm should be treated and by what recommended method, to comment if the risk/benefit of treatment is unclear, or treatment is not recommended, and to document the risk of no treatment compared with the risks of all treatment options. The Health Board also agreed to share the final report with relevant clinical staff for critical reflection.

Cwm Taf Morgannwg University Health Board - Clinical treatment outside hospital
Case Number: 201903590 - Report issued in September 2020

Mrs M complained that failings in the care and treatment that her late son, Mr B, received from mental health services provided by the Health Board, contributed to his tragic suicide in February 2018. Mrs M complained that:

a) Assessments and care-management interventions conducted by clinicians during 2016 and 2017 failed to adequately identify and treat Mr B's deteriorating mental health.
b) Clinicians failed to appropriately exercise their powers to detain Mr B under the provisions of the Mental Health Act 1983 ("the MHA").
c) Clinicians failed to follow up or further engage with Mr B after his discharge from the Royal Glamorgan Hospital ("the Hospital").
d) Following Mr B's suicide on 27 February 2018, the family went to view his body at the Hospital's Emergency Department ("ED"). They were shocked to discover that no attempt had been made to conceal the ligature marks around Mr B's neck or the bruising sustained in attempts made to resuscitate him.

The Ombudsman **did not uphold** complaints 1 and 2. He found that the care that Mr B received from clinicians during 2016 and 2017 was of a good standard and that there were no grounds to detain Mr B under the provisions of the MHA. The Ombudsman **upheld** complaint 3 and determined that Mr B's discharge was unsatisfactory. However, he could not conclude that an inadequate discharge plan directly caused or contributed to Mr B's subsequent deterioration (and decision to end his life some 3 months later). The Ombudsman **upheld** complaint 4. He concluded that the failure to protect Mr B's dignity in

death and to take steps to ensure that the family's distress was minimised were serious shortcomings that were a source of significant injustice to the family.

Finally, the Ombudsman concluded that, despite the identified shortcomings, he had seen no compelling, causal evidence that could definitively link Mr B's decision to end his life to the actions or omissions of clinicians.

The Ombudsman recommended that the Health Board provide Mrs M with a formal apology and a redress payment of £1000 in recognition of the distress that the identified failings gave rise to. He recommended that his report is disseminated and reflected upon by the relevant senior medical and nursing staff within the Mental Health Directorate, and that changes should be made to its post-discharge, follow-up policy. The Ombudsman also recommended that ED clinicians undergo training/revision of the HRA and its relevance to their work.

The Health Board agreed to implement these recommendations.

Cardiff and Vale University Health Board - Appointments/admissions/discharge and transfer procedures Case Number: 201901286 - Report issued in September 2020

Mrs T complained that her late mother-in-law, Mrs G, was prematurely and unsafely discharged from University Hospital Llandough following a hip replacement operation. Mrs T complained that Mrs G was allowed home with symptoms of fever and that, sadly, within 4 days, she developed pneumonia and died. Mrs T also complained that:

1) Mrs G was discharged despite clinicians being informed by the family that her home was undergoing refurbishment and would not be habitable for some considerable time.
2) Clinicians did not take into account the fact that Mrs G cared for her grandson who suffered with Cystic Fibrosis.
3) Clinicians involved in her discharge did not consider the fact that Mrs G could not easily access a downstairs toilet. A commode provided to her was unsatisfactory as she was unable to empty it without help. This compromised her dignity.
4) The family informed visiting home care staff and District Nurses (DNs) that Mrs G suffered an episode of diarrhoea following her discharge, but this was not acted upon.

The Ombudsman found no evidence that Mrs G was allowed home with symptoms of fever (or any other indication of illness) and determined that her discharge was clinically safe. However, he upheld complaints 1-4. With regard to complaint 1, the Ombudsman found that this communication failure resulted in considerable inconvenience for the family who were obliged to urgently prepare the home for Mrs G's return.

With regard to complaint 2, the Ombudsman found that clinicians failed to consider that Mrs G's grandson was a minor who, since his grandmother's admission, had been living alone with a serious (and possibly life-limiting) condition. The Ombudsman was concerned that no attempt was made to check on his welfare and, in view of the risk to which he was exposed, considered that this amounted to a safeguarding failure.

With regard to complaint 3, the Ombudsman found that clinicians failed to identify, record or discuss the nature of the physical difficulties that having an upset stomach raised for Mrs G and for how her commode was to be emptied. The Ombudsman found that this would have placed an inappropriate pressure on Mrs T to manage the physical consequences of the problem in order to help preserve her mother-in-law's dignity. With regard to complaint 4, the Ombudsman found that there was an abiding failure of DNs and care staff to assess, monitor and record a plan of care in relation to Mrs G's reported

diarrhoea.

The Ombudsman recommended that the Health Board provide Mrs T with an apology for the identified failings and, in recognition of their consequences, make a payment to her of £500. He also recommended that:

- The report is shared with all of the teams involved in Mrs G's discharge and post-discharge care.
- A review/revision of safeguarding practice is carried out and references to safeguarding in the Health Board's Discharge Policy are reviewed and updated.
- An audit of compliance with Hospital Discharge Procedure (in respect of a sample of patients) is conducted.
- An Action Plan is implemented which addresses the identified failings of all the teams involved in Mrs G's discharge planning and care delivery.

The Health Board agreed to implement these recommendations.

Not Upheld

A GP Practice in the area of Cwm Taf Morgannwg University Health Board - Clinical treatment outside hospital

Case Number: 201901378 – Report issued in July 2020

Mrs B complained about the delay in diagnosing Deep Vein Thrombosis (DVT) and sepsis in her mother (Mrs P) in March and November 2017, respectively. Mrs B said that DVT was eventually diagnosed on 24 March 2017 but that GPs had missed opportunities to identify the problem sooner. Mrs B was concerned that the failure to identify and treat sepsis on 21 November contributed to Mrs P's death.

The Ombudsman found that due to Mrs P's complex medical history, the GPs who reviewed her in March 2017 could not reasonably have been expected to positively diagnose DVT. In relation to sepsis, there was no evidence that Mrs P's infection had developed into septic shock which would have required urgent identification and treatment. The Ombudsman found that the care provided by the GP on 21 November was reasonable. The Ombudsman **did not uphold** the complaints.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201901766 – Report issued in July 2020

Mrs X complained about the care provided to her mother, Mrs Y, during her admission to Llandudno General Hospital ("the Hospital") between 8 and 17 October 2018 following a fall at home. The investigation considered whether the Health Board:

a) Failed to appropriately manage Mrs Y's mobility needs.
b) Failed to convene a multi-disciplinary ("MDT") meeting before Mrs Y's discharge to satisfy itself that the decision was appropriate.
c) Inappropriately discharged Mrs Y home on 17 October.
d) Failed to assess the suitability of Mrs Y's bungalow before discharge and whether it was a suitable location for her to be discharged.
e) Failed to arrange respite care following discharge.

The Ombudsman found that the rehabilitation Mrs Y received at the Hospital to improve her mobility was appropriate, and with physiotherapy input she had regained her baseline mobility. Mrs Y was not considered to be a complex discharge and the decision not to convene an MDT meeting before her discharge was appropriate and in line with the Health Board's discharge policy. Mrs Y was medically fit

and back to her functional mobility level; the decision to discharge was therefore appropriate. A home visit to assess the suitability of Mrs Y's bungalow was not required; she was back to her pre-admission mobility and her living arrangements (including adaptations already in her home) were suitable. Finally, the Health Board was not responsible for arranging respite care. The Ombudsman did not uphold the complaints.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201903268 – Report issued in July 2020

Mrs X complained about the care and treatment provided to her late husband, Mr X, by the Health Board between 26 May and 11 June **2018**. In particular, Mrs X complained that the Health Board had failed to undertake further investigations of Mr X's bladder, heart, and liver during his hospital stay, had failed to provide palliative care to Mr X, and did not properly communicate with Mr X.

The Ombudsman found that it was reasonable for the Health Board to have treated Mr X's primary diagnosis of a pulmonary embolism (a blocked blood vessel in the lungs) while he was an inpatient and to arrange for further investigations to be undertaken following Mr X's discharge from hospital. The investigation found that Mr X was not considered to be in a palliative state as he had not undergone all investigations, nor had a multi-disciplinary team meeting discussed his care. Finally, the Ombudsman found that the Health Board had, overall, communicated with Mr X appropriately and in line with national guidance.

The Ombudsman identified one instance in which a Gastroenterology review of Mr X's condition was not communicated to him, although found that this did not cause an injustice to Mr X. Mrs X's complaints were therefore **not upheld**. However, the Ombudsman **suggested** to the Health Board that it share his report with the Gastroenterology team to facilitate learning regarding its communication with patients and ensuring significant discussions with patients are recorded in the clinical notes.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201807567 – Report issued in July 2020

Mrs A complained that the Health Board failed to refer her late husband, Mr B, for further investigation of his enlarged prostate, delaying his cancer diagnosis. Mrs A believed that, because Mr B had to drain his bladder by self-catheterisation, he was unlikely to experience the range of urological symptoms that might indicate prostate cancer, prompting a referral for further investigations. Therefore, Mrs A felt that closer monitoring and treatment of Mr B's enlarged prostate were merited.

The Ombudsman found that there was no known association between enlargement of the prostate and the development of prostate cancer. Further, routine screening to detect early prostate cancer would not have been recommended for Mr B as he was not in a high-risk group. As there was no evidence that more should have been done by the Health Board in response to Mr B's enlarged prostate, the complaint was not upheld.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201902341 – Report issued in July 2020

Mrs Y was 80 years old with a history of atrial fibrillation (irregular heartbeat), hypertension (high blood pressure), vascular problems and she could not fully straighten her leg. On 29 August **2018**, Mrs Y's GP wrote a referral letter to the Withybush General Hospital ("the Hospital") stating that the Podiatrist and District Nurse requested Mrs Y's admission because of spreading necrosis (the death of tissue due to disease, or a failure in blood supply) and systemic decline. The GP had not seen Mrs Y, but asked that Mrs Y was assessed.

Ms X complained about Mrs Y's assessment, treatment and discharge on 29 August 2018. Mrs Y was re-admitted 3 days later on 1 September and Ms X complained whether her mother had an urine infection at this admission. Sadly, Mrs Y died on 8 September.

The Ombudsman found that Mrs Y's wellbeing was not noted, her wound was not examined, a wound swab was not taken and the sepsis screening was not recorded. However, these service failures did not lead to an injustice, as even had Mrs Y's wound shown evidence of local infection, there was no evidence of sepsis being triggered, and she was prescribed antibiotics before discharge. The Ombudsman also found that there was no documentation for Mrs X's care with the Nurse, but as the Nurse saw Mrs X after discharge, there was no injustice. The Ombudsman did **not uphold** this aspect of the complaint.
The Ombudsman found that on 1 September Mrs Y had evidence of a urine infection. Mrs Y had multiple comorbidities and her management was reasonable. The Ombudsman did **not uphold** this aspect of the complaint.

The Ombudsman **invited** the Health Board to review whether a policy for GP for vascular referral was required, to review its referral process to specialist teams, and for the Doctor to reflect on his recording within Emergency Department documentation.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201901411 – Report issued in July 2020

Ms A complained about the care that she received from Aneurin Bevan University Health Board for an ovarian cyst (a fluid-filled sac which develops on an ovary). She said that the Health Board did not report its ultrasound scan of that cyst fully and accurately, that it did not treat it satisfactorily when she attended 1 of its Emergency Departments ("the Emergency Department") and that it did not prioritise its surgical treatment appropriately.

The Ombudsman found that the Health Board's ultrasound scan report was correct and that it contained the information needed to assess Ms A's risk of malignancy. He considered that the Health Board had calculated that risk correctly and that there was no evidence that Ms A had had any of the complications associated with an ovarian cyst when she attended the Emergency Department. He determined that the Health Board's treatment of Ms A's cyst during that attendance was appropriate. He found that the Health Board had, given its assessment of Ms A's malignancy and complication risks, prioritised the surgical treatment of her cyst appropriately. He did not uphold Ms A's complaint.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201904379 - Report issued in August 2020

Dr X complained that the Health Board failed to diagnose and appropriately treat his late mother, Mrs Y's, heart condition. Dr X also complained that Mrs Y was inappropriately discharged from hospital.
The investigation found that Mrs Y had correctly been diagnosed with Non-ST-segment elevation myocardial infarction ("N-STEMI", when the blood supply to the heart is suddenly blocked) by a different health board prior to her transfer to a hospital managed by the Health Board. The Ombudsman found that the treatment plan and procedures undertaken by the Health Board in treating the N-STEMI were appropriate.

The investigation also found that the Health Board appropriately assessed Mrs Y's ongoing care needs prior to her discharge, and there was no clinical indication for her to have remained in hospital for a longer period. Dr X's complaints were therefore **not upheld**.

Complaint against a GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 201904691 - Report issued in August 2020

Mr X complained that the care and treatment provided to him by a GP ("the GP") based at the Surgery during a consultation held on 29 July 2019 was not clinically appropriate.

The investigation found that the accounts of the consultation given by Mr X and the GP were conflicting. Usually, evidential weight is given to the supporting documentary evidence; however, in this case Mr X

said that the clinical records were falsified. The investigation found no evidence to suggest that the GP had any reason to mispresent the discussion held at the consultation and the examination undertaken. However, as a consequence of the specific allegation of falsification by Mr X, the Ombudsman was unable to allow the documentary evidence to "tip the scales" in terms of the weight of the evidence. There was a lack of independent and corroborative evidence and therefore the investigation could not reach a firm conclusion as to which was the more accurate account given the extent of Mr X and the GP's polarized views. In the absence of impartial evidence, no finding was reached on the complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201808009 - Report issued in August 2020

Ms E expressed concern about the care given to her late partner, Mr F, by Aneurin Bevan University Health Board. She complained that the Health Board had not managed Mr F's falls risk appropriately, that it had not responded to a fall that he had had properly and that it had not managed his pressure ulcer risk correctly. She also complained that it had not pursued a referral for a second opinion about Mr F's biopsy sample (a small piece of body tissue that has been removed for examination under a microscope).

The Ombudsman found that the Health Board had, on balance, managed Mr F's falls risk appropriately. He did not uphold this aspect of Ms E's complaint. He was satisfied that the Health Board had responded properly to the fall identified by Ms E. He did not uphold this part of Ms E's complaint. He determined that the Health Board had managed Mr F's pressure ulcer risk correctly. He did not uphold this element of Ms E's complaint. He noted that the Health Board had not pursued the biopsy-related referral that it had made in respect of Mr F. However, he did not consider that that amounted to a service failing for 2 reasons. Firstly, he found that it had initially been clinically reasonable for the Health Board to allow some time for the second opinion to be provided due to the complexity of Mr F's biopsy sample. Secondly, he accepted that the subsequent deterioration in Mr F's condition meant that his biopsy result was no longer required to manage his clinical care. He did not uphold this aspect of Ms E's complaint.

Velindre University NHS Trust - Other
Case Number: 201802635 - Report issued in August 2020

Ms E expressed concern about the care given to her late partner, Mr F, by Velindre University NHS Trust. She complained that the Trust had not ensured that a biopsy (the removal of a small sample of body tissue for examination under a microscope), which Mr F needed, was completed promptly. She also complained that it had not chased up the result of that investigation.

The Ombudsman found that the timing of Mr F's biopsy was reasonable. He took into account, when reaching that view, Mr F's fitness level, the need to investigate Mr F's symptoms and the requirement for a restaging CT scan (this is used to find out whether cancer has spread) and a multidisciplinary discussion before the biopsy was performed. He did not uphold the biopsy completion part of Ms E's complaint. He did not consider that the extent to which the Trust chased up Mr F's biopsy result would amount to a service failing for 2 reasons. Firstly, he noted that the Trust had known that Mr F had been admitted to a local hospital. Secondly, he accepted that the deterioration in Mr F's condition meant that his biopsy result was no longer required to manage his clinical care. He did not uphold the biopsy result aspect of Ms E's complaint.

Cardiff and Vale University Health Board - Other
Case Number: 201800151- Report issued in August 2020

Ms E complained about the service that her late partner, Mr F, had received from Cardiff and Vale University Health Board. She said that the Health Board had not completed a supplementary pathology report, about Mr F's biopsy sample (a small piece of body tissue removed for examination under a microscope), within a reasonable time frame.

The Ombudsman found that the Health Board took a considerable period of time to complete a report about Mr F's biopsy sample ("the biopsy report"). He noted that the Consultant Pathologist

("the Consultant Pathologist") involved was unable to complete that report for some time because he was on leave. He also acknowledged that there was no one else within the Health Board who had the expertise required to complete that report. Nonetheless, he considered that the Health Board was likely to have contributed to the delay that occurred because it did not inform the health body concerned that the Consultant Pathologist was not available when it received its referral for a second opinion. He determined that that omission, which could have been avoided, amounted to a limited service failing. However, he accepted that the earlier completion of the biopsy report would not have altered Mr F's clinical management plan or the outcome for him. Consequently, he could not determine that Mr F had suffered an injustice because of the limited service failing identified. He did not uphold Ms E's complaint as a result.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201904789 - Report issued in September 2020

Mr A complained that there was a delay by Betsi Cadwaladr University Health Board in diagnosing his wife, Mrs A's cardiac amyloidosis. Cardiac amyloidosis is an extremely rare, serious condition caused by a build-up of an abnormal protein called amyloid in the heart which cause the muscles to become stiffer, making it more difficult to pump blood around the body.

The Ombudsman found that, in retrospect, Mrs A displayed several symptoms that were consistent with cardiac amyloidosis between January and August. During this time she was treated for pneumonia and pulmonary embolism which would have contributed to her symptoms and may have distracted attention from her cardiac symptoms. However, the Ombudsman was satisfied that the symptoms displayed by Mrs A were not specific or diagnostic of cardiac amyloidosis. There was no diagnostic evidence of cardiac amyloidosis until an echocardiogram was performed in August and, consequently, Mrs A's cardiac amyloidosis could not have been diagnosed sooner. Therefore, Mr A's complaint was not upheld.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201904142 - Report issued in September 2020

Mrs X complained about an injection that was administered to her by Swansea Bay University Health Board ("the Health Board") on 23 February 2019. Specifically, Mrs X complained that following the injection, she suffered significant side effects, including, a loss of memory between the 23 and 25 February, an infection in her legs and a swollen hand.

The Ombudsman's investigation found that the prescription of the injection was appropriate, indicated and was in keeping with the relevant clinical guidance. The Ombudsman also found that the injection was administered at the correct dosage and that the side effects Mrs X described were not anticipated to occur as a result of the injection and are unlikely to be linked to it. As a result, the Ombudsman did not uphold the complaint.

A GP Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201901811 - Report issued in September 2020

Mrs G complained that the Practice failed to take appropriate and timely action, on more than one occasion, in relation to her late father's ("Mr V") ingrowing toenail. Specifically, Mrs G said that there was a failure of care by Dr C who refused to visit her father at home, failed to admit Mr V to hospital, failed to refer Mr V to social care and suggested he attend the Practice to pick up his medication when he was physically unable.

The Ombudsman found that the care and treatment afforded to Mr V, and in particular by Dr C, was within the range of appropriate clinical practice. When no doctor was available to visit Mr V, it was not unreasonable for him to be told to contact the out-of-hours GP service if his condition worsened.

The Ombudsman also found that Mr V was admitted to hospital shortly after a discussion between Dr C and Mrs G. In addition, the Ombudsman thought it reasonable for either Mrs G or Mr V to prompt the

Practice regarding Mr V's social care needs. Finally, the Ombudsman could find no evidence that Mr V was told to pick his own medication up when he was physically unable.
The Ombudsman did not uphold the complaint.

Early Resolution or Voluntary Settlement

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 202000179 – Report issued in July 2020

Mrs X complained about the care provided to her late husband at the Prince Charles Hospital. She had complained to the Health Board by letter in September 2019. Mrs X then sent the Health Board additional concerns to be addressed in an email in October 2019. The Health Board provided Mrs X with a formal written response in March 2020. However, whilst that letter included the Health Board's responses to the issues raised in the letter of September, it did not address the concerns raised in the email sent in October.

The Ombudsman contacted the Health Board which subsequently agreed to apologise to Mrs X for failing to address the concerns raised in the email of October and to respond to those issues within 3 months. No decision would be taken by the Ombudsman on whether Mrs X's other concerns should be investigated until Mrs X had been provided with the Health Board's response to the concerns set out in the email of October 2019.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202000295 – Report issued in July 2020

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

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

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

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

a) *The Medical Director should consider the content of the neurology report and seek advice on how best to meet Mr X's needs, and write to Mr X to explain any proposed clinical pathway*

The investigation was therefore discontinued as the Health Board's actions resolved the complaint.

Betsi Cadwaladr University Health Board - Non-medical services
Case Number: 202000824 – Report issued in July 2020

Mr X complained to the Ombudsman about the manner in which the Health Board had reviewed a decision restricting Mr X to contacting the Health Board by post only. In its decision letter to Mr X conveying the outcome of the review, the Health Board told Mr X to contact the Ombudsman if he was dissatisfied with its decision.

However, having considered the relevant Health Board procedure, it became evident that there was

provision in the procedure for an individual to appeal the restriction imposed. The Health Board did not, when conveying its decision to Mr X, make him aware that he could appeal the restriction. The Health Board therefore agreed to:

a) write to Mr X to apologise for inviting him to refer his concerns to the Ombudsman when there was still an opportunity available for him request an appeal of the decision; and
b) invite Mr X to submit his appeal in line with Paragraph 7 of the Health Board's "Dealing with Unreasonable Behaviour Procedure and Guidance for staff " if he wished to do so and for the Health Board to explain the basis upon which any appeal would be considered.

Powys Teaching Health Board - Clinical treatment in hospital
Case Number: 201906803 – Report issued in July 2020

Mrs A complained about the care and treatment received by her daughter, Mrs B, during the antenatal and postnatal period of her pregnancy; specifically in relation to the management of her diabetes and thyroid medication.

Following a meeting between the Health Board and Mrs A and Mrs B (after the Ombudsman's investigation had begun), the Health Board agreed to commission an expert to complete an independent review of the care and treatment received by Mrs B within 6 months. The Health Board also agreed, within 3 months, to develop a clear pathway for women who take thyroid medication to support their needs during antenatal, labour and postnatal periods of care. Finally, it also agreed to undertake a review of the management of concerns by the Health Board to identify areas of learning and/or improvement. The Ombudsman considered that the agreed actions represented a reasonable resolution to Mrs A's complaint and so he discontinued his investigation.

Cardiff and Vale University Health Board - Continuing care
Case Number: 201904969 – Report issued in July 2020

Mr X complained on behalf of his mother, Mrs Y. Mr X complained that, between February 2018 and November 2019, Cardiff and Vale University Health Board ("the Health Board") did not follow the proper process and procedure when assessing Mrs Y's eligibility for NHS Continuing Health Care funding ("CHC funding") to pay for her residential care fees upon discharge from hospital. Mr X also said that the Health Board did not handle his complaints properly.

In response to the Ombudsman's proposal to commence an investigation, the Health Board advised that it had suggested a further formal meeting with Mr X and his siblings. If agreement could not be achieved at the meeting, the case would be considered by the Independent Review Panel at the first opportunity. The Health Board explained that Mrs Y had remained cared for in hospital throughout, and there had been no financial cost for her care to herself or her family.

The Ombudsman remained concerned that the procedures for determining Mrs Y's continuing health care needs with her family and professionals had not been appropriately followed in April and in October 2018. The Ombudsman also had some concerns regarding the Health Board's delayed acknowlement and response to Mr X's complaints. He was concerned that these matters had caused additional stress and upset for Mr X and his siblings who were already anxious about their mother.

The Health Board agreed to apologise to Mr X and his family for the procedural failings identified, and to put in place within 4 months a standard agenda for the smooth management of formal meetings in continuing health care cases. It also agreed to offer a range of meeting dates to consider Mrs Y's eligibility for Mr X to choose from.

Welsh Ambulance Services NHS Trust - Ambulance Services
Case Number: 202000982 - Report issued in August 2020

Ms A complained about non-emergency patient transport services provided by Welsh Ambulance Services NHS Trust ("the Trust"), which included transport being unavailable or arriving late. Ms A also complained about poor communication and arrangements not being confirmed and was unhappy with the Trust's complaint response.

The Ombudsman considered that the Trust had undertaken a thorough investigation of the complaint and provided a detailed response in which it has acknowledged shortcomings and provided an adequate apology, where appropriate. Steps were being taken to review and improve services within the Journey Coordination Centre and work was underway with the Health Board to improve the commissioned service. However, a meeting between Ms A and the Trust was planned but did not take place which meant that Ms A did not receive the full explanation and outcome envisaged.

The Trust agreed to provide Ms A with a more detailed complaint response setting out details of the improvements that had been identified and any measures implemented or planned to prevent a recurrence of the problems she had experienced within 20 working days.

The Ombudsman's view was that the above action was reasonable to settle Ms A's complaint.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 202000847 - Report issued in August 2020

Mr X, a patient of Swansea Bay University Health Board complained about the mental health services he had received. In particular he had not been provided with any Occupational Therapy input, a psychotherapy referral had not been progressed and he was not allocated a CPN. He further complained about the treatment received at a consultant appointment. Mr X also complained about aspects of the complaint response, as some matters had not been addressed and he had not been provided with a copy of the complaint response by the Health Board.

The Ombudsman declined to investigate and considered that the Health Board's assessments, decisions and actions taken appeared reasonable. However, Mr X had not been provided with a clear explanations of the reasons for those decisions and some aspects of the complaint had not been addressed fully.

The Health Board agreed to provide Mr X with a full written explanation as to the reasons why a CPN had not been allocated and a referral for psychotherapy was not processed, within 20 working days. This was to include providing him with details of any assessments undertaken. The Health Board also agreed to, within 20 working days, provide an apology for its failure to send a copy of the complaint response to Mr X.

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

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201906291 - Report issued in August 2020

Mrs A complained about the care and treatment provided to her late father, by Hywel Dda University Health Board ("the Health Board"), that he was not diagnosed and treated in a timely manner and was discharged prematurely following the first admission. Concerns were raised about whether fractured ribs and haemothorax were missed, pain management and the advice provided on discharge. Mrs A felt there was a lack of consideration and understanding of dementia patients. She was unhappy with aspects of the complaints handling and that the complaint response took 7 months.

The Ombudsman was satisfied that the diagnosis made during the first admission and the decision to discharge the patient was reasonable based on the information available at the time. The Ombudsman was concerned about aspects of pain management, the communication on discharge and the failure to offer a follow up appointment, particularly as the patient had dementia.

In settlement of the complaint, the Health Board agreed to provide an apology for poor communication with the patient's family, failing to provide analgesia and failing to provide a follow up appointment to the patient on discharge. It agreed to review, in conjunction with the Health Board's dementia specialist, the patient's pain management and discharge and its discharge guidance. The Health Board also agreed to provide a further response to Mrs A detailing any measures identified to prevent a recurrence of the problems experienced. All actions were to be undertaken within 30 working days.

Betsi Cadwaladr University Health Board - Other
Case Number: 202001095 - Report issued in August 2020

Mr A complained about the standard of service received from the North Wales Community Mental Health Team. He said he could not contact the Team and that appointment information was sent to an incorrect address. He also complained about a consultant psychiatrist's lack of professionalism during an appointment. He wanted a reassessment of his mental health needs and improvements in the Team's telephone system.

The Ombudsman concluded that the Health Board had already taken sufficient action to improve communication and explain the actions of the Consultant Psychiatrist. However, he contacted the Health Board as he was concerned that Mr A had not been provided with a further appointment following a change in his social worker and a letter had been sent to his old address. He was also concerned that Mr A had not been provided with relevant discharge information and support.

The Health Board confirmed that although Mr A had attended a further appointment, the outpatients letter sent to Mr A and his GP was not of expected standards. Therefore, it agreed to arrange a further appointment so that Mr A's mental health needs could be reassessed, and the correct discharge information could be provided to him. The Ombudsman was satisfied that this action was reasonable and resolved the complaint. He reminded the Health Board of the importance of ensuring that outpatient letters conform with expected standards.

A Medical Centre in the area of Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 202000513 - Report issued in August 2020

Mr X complained about the treatment he received in relation to recurring attacks of gout. Specifically, about the management of his treatment plan and the advice received.

The Ombudsman noted there was no explicit discussion recorded in Mr X's medical notes showing that sufficient information had been given about his condition and the side effects of the medication allopurinol. However, the Ombudsman recognised that as Mr X had experienced frequent attacks of gout, it was unlikely that a more detailed discussion about the use of allopurinol would have led to a radically different treatment plan being advised, or that he would not have suffered repeat episodes of gout. The Ombudsman recognised Mr X was unhappy that he had not been advised to attend consultations with the same GP throughout the course of his treatment, but found no clear reason for this to have occurred.

The Ombudsman found that the care which Mr X received was generally reasonable and appropriate, but he noted that consultations that took place in October and November 2019 showed a different approach to the management of gout prophylaxis, which omitted to take full account of the National Institute for Health and Care Excellence guidance, (2018) Clinical Knowledge Summary Gout.

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

- To use Mr X's complaint to facilitate learning in relation to NICE guidance and recording on the use of allopurinol when prophylaxis for gout is started. The complaint would be discussed and any learning needs identified at the Significant Event Review meeting, scheduled to take place week commencing 14 September 2020.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201807867 - Report issued in September 2020

Mrs A complained about her late uncle's care and treatment at Glan Clwyd Hospital. Specifically, Mrs A said that the Health Board had unreasonably delayed reaching a terminal cancer diagnosis, limiting Mr B's end of life care choices. She also raised concerns about the Health Board's failure to meet his nutrition and hydration needs, to administer his pain medication in an effective and timely manner, and about the response to her complaint.

The Ombudsman found it unlikely that Mr B's terminal diagnosis could have been confirmed more quickly, or that his end of life care choices would have been limited as a result of any delay. However, the family were given conflicting and inappropriate diagnostic information about the seriousness of Mr B's condition by different medical teams. The Health Board also failed to put a robust end of life care plan in place for Mr B meaning that his choices and wishes were not established. The failure to show respect for Mr B's end of life care choices engaged his human rights under Article 8.

The Ombudsman also found that hydration monitoring was not undertaken consistently, and that nutritional screening was not undertaken in a timely manner. Appropriate nutritional support for Mr B, who could not eat, was delayed for 7 days and the Health Board could not ensure that his hydrations needs were met. Furthermore, there was no evidence of appropriate assessment of Mr B's pain in the last days of his life to ensure a timely response.

Finally, the Ombudsman found that the Health Board made comments that were not supported by the medical records in its written response to Mrs A's complaint. When challenged by Mrs A over the content of its response, the Health Board failed to reply, giving her the impression that her concerns were not taken seriously.

The Ombudsman recommended that the Health Board should apologise to Mrs A, and pay her £500 for the failures identified and distress caused. The Health Board was also asked to ensure that the Consultant who gave the inappropriate diagnostic information undertook a piece of reflective practice, and that the nursing staff involved in Mr B's care undertook refresher training in nutrition screening and assessment, hydration assessment and end of life care planning. Finally, the Health Board was asked to evidence to the Ombudsman that national guidance was being followed to ensure that every end of life patient had a suitable plan of care in place.

Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 202001125 - Report issued in September 2020

Ms A complained about the care and treatment provided by Aneurin Bevan University Health Board ("the Health Board") to her father in the months prior to his below the knee amputation.

The Health Board voluntarily decided to re-consider Ms A's complaint. It subsequently referred the matter to its Redress Panel. The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (more commonly known as Putting Things Right) states that where a concern includes an allegation that harm has, or may have been caused, the Health Board must have regard to the likelihood of a qualifying liability (a qualifying liability arises when the Health Board's investigation identifies a breach of its duty of care which results in harm to a patient). It then has a duty to consider redress. This is the purpose of the Redress Panel.

The Health Board agreed to consider Ms A's complaint at its Redress Panel on 5 November 2020 and to inform Ms A of the outcome within one month thereafter, keeping her updated in the interim.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202000736 - Report issued in September 2020

Mr and Mrs X complained about the standard of care provided to their young son, A, following his diagnosis with a rare genetic condition. Whilst Betsi Cadwaladr University Health Board ("the Health Board") had provided a written response to their complaint, they felt that there remained issues which had not been explained. They were also concerned about the amount of time it had taken for the Health Board to provide a formal response to their complaint.

The Ombudsman found that there were aspects of the complaint that had not been addressed by the Health Board in its response. The Health Board therefore agreed to provide a further written response to Mr and Mrs X covering the following three points:

1) Lack of co-ordinated care plan to provide physiotherapy, SALT and dietetic care for A's specific needs between September 2019 and January 2020.
2) Delay and oversight in making an Opthalmology referral in January 2020.
3) Delay in providing a formal complaint response (October 2019 to May 2020).

The Health Board agreed to provide this response within one month of the date of the Ombudsman's decision.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202000983 - Report issued in September 2020

Ms Y complained about mental health services provided by the Home Treatment Team and the lack of communication about changes in arrangements. In May 2019, Ms Y ran out of medication when another patient's medication was brought in error. She was unable to contact the team to discuss this at a time when she had been told that the service would be available and she complained about the tone and attitude of the staff member she later spoke to. Ms Y was unhappy with the Health Board's complaint response, which did not identify or explain any changes made to improve the service. She said the response did not reflect the situation, minimised her concerns, failed to appreciate the impact this had on her and did not address all the matters raised.

The Ombudsman considered that the Health Board's investigation of the complaint had appropriately identified and acknowledged shortcomings in communication for which it apologised and learning points had been discussed with staff. However, the complaint response did not reflect that Ms Y had run out of her medication and the Health Board did not appear to have introduced measures have to prevent a recurrence of the difficulties experienced regarding the provision of medication. The complaint response did not address the issue of Ms Y being unable to contact and access the service.

The Health Board agreed to, within 20 working days, consider and review the current practices, procedures and guidance to see what more could be done to ensure medication is provided in a timely manner and that patients do not run out of medication. It also agreed to provide Ms Y with details of any measures introduced to prevent a recurrence of the problems experienced. The Health Board also agreed to provide Ms Y with a further written response addressing her inability to access the service and an apology for failing to respond to this aspect of her complaint previously.

The Ombudsman's view was that the above action was reasonable to settle Ms Y's complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202002037 - Report issued in September 2020

Mr L complained about the dose of medication provided by Aneurin Bevan University Health Board ("the Health Board"). He said that for over 4 months, he complained to the clinician that the dose was too high, and although she initially agreed to reduce the dose, she then changed her mind. He said that the dose caused him to suffer seizures and when the dose was finally reduced, the fits more or less stopped.

The Ombudsman found that in its response to Mr L's complaint, the Health Board had not addressed his concerns about the dose of his medication, or the actions of the clinician in dealing with Mr L's requests for it to be lowered.

The Ombudsman contacted the Health Board and it agreed to – within 30 working days:

- Provide a further comprehensive written response to Mr L, addressing his concerns about the dose of his medication, his requests over a 4 month period for it to be reduced and his suggestion that his clinician initially agreed to reduce the dose, before subsequently changing her mind.

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: 202000890 - Report issued in September 2020

Mr Y accessed private psychiatric consultations in April and May 2019. He was diagnosed with adult ADHD (Attention Deficit Hyperactivity Disorder) and prescribed medication accordingly. Mr Y sought to have his diagnosis recognised with the Health Board so that his medication could be prescribed within the NHS. My Y complained to the Ombudsman that the Health Board had failed to follow NICE guidance for assessment of adult ADHD during his assessment in September 2019. My Y said that this impacted the outcome of the assessment in that a diagnosis of adult ADHD was not found and therefore the Health Board was not prepared to prescribe his medication within the NHS. Mr Y said that the Health Board had been inconsistent and that it had ignored evidence within his medical records to support a diagnosis of ADHD.

The Ombudsman found that there was miscommunication over the type of assessment Mr Y believed he was due, to the one that was undertaken. Additionally, the Health Board informed Mr Y that he was entitled to a second opinion, but it subsequently declined his request deeming it unnecessary.
The Ombudsman contacted the Health Board and it agreed to offer Mr Y a second opinion, whereby the assessing clinician was aware of the background.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 202000842 - Report issued in September 2020

Mrs A complained about the care and treatment provided by the GP Out of Hours Service to her sister, Mrs B, in April 2020 during two telephone consultations.

The Ombudsman found that there was lack of documenting within the medical records, in relation to potential side-effects of the medication prescribed to Mrs B at the first consultation or what information had been given to her in this regard. The Ombudsman found that the medication prescribed to Mrs B at the second consultation was not appropriate and was ineffective. Additionally, that the decision for the second consultation to be carried out remotely rather than face to face, was not within the range of appropriate clinical practice.

The Ombudsman recommended that the Health Board apologised to Mrs B for the service failures identified, acknowledging the distress caused to her. The Ombudsman also recommended that the Health Board issued a reminder to practitioners within the GP Out of Hours Service to document information in the medical records about potential side-effects and that potential side-effects have been explained to patients. Finally, he recommended that the Health Board utilised an anonymised version of the case as a learning tool to highlight to practitioners the necessity of a face to face consultation in some cases (with suitable precautions in place to minimise the risk of transmission of Covid-19).

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 202001215 - Report issued in September 2020

Mrs X complained about the standard of care and treatment that her brother received whilst he was a patient at Prince Charles Hospital in December 2019. Despite Mrs X receiving the Health Board's response to her complaint, she remained dissatisfied.

Having considered Mrs X's complaint alongside the Health Board's response, the Ombudsman was of the view that the Health Board had fully addressed her complaint. However, the Ombudsman noted that Mrs X had raised additional questions concerning her brother's discharge and sepsis which she had not brought to the attention of the Health Board. The Ombudsman considered that the outstanding questions formed the underlying basis of why she remained dissatisfied. Therefore, he concluded that it would be helpful to Mrs X to receive a response from the Health Board.

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

a) To contact Mrs X within 30 days from the date of the Ombudsman's decision being issued, in order to make the necessary arrangements to convene a meeting during which her questions would be addressed.

Complaints Handling

Upheld

Swansea Bay University Health Board - Health

Case Number: 201900510 - Report issued in July 2020

Mr Q complained that Swansea Bay University Health Board delayed referring his father Mr T, for surgery in January 2018 following the discovery of an abdominal aortic aneurysm ("AAA"). Mr Q also complained about the management of Mr T's diagnosis up until his surgery on 13 June to repair the ruptured AAA and about the Health Board's overall communication with him between January and June 2018.

The Ombudsman found that Mr T's AAA was measured in a timely manner following referral and, due to Mr T's other significant health issues, further tests were needed to be carried out before proceeding with his surgery. The Ombudsman did not uphold this part of the complaint.

The Ombudsman, however, was concerned with the Health Board's communication with Mr T, in particular, with regard to when he would have his surgery. Whilst the Health Board met Welsh Government guidelines on waiting times, it had not made Mr T aware of the guidelines and had given him an unrealistic timeframe for surgery. This misinformation was compounded further when Mr T's AAA ruptured, and he sadly died 9 days later. The Ombudsman upheld this part of Mr Q's complaint.

The Ombudsman recommended that the Health Board apologise to Mr Q. He also recommended that the report's findings were used to better improve communication with patients in relation to waiting times with the focus on improving the timeliness of updates. The Health Board agreed to the recommendations.

Cardiff and Vale University Health Board – Health

Case Number: 201904621 - Report issued in August 2020

Mr B complained about the care and treatment his brother-in-law, Mr C, received from Cardiff and Vale University Health Board ("the Health Board"). Mr B said that the different clinicians involved in Mr C's care failed to properly communicate with each other and remained focused on their own specialism, which meant that there was a failure to address Mr C's clinical needs.

Mr B also complained that the Health Board failed to properly investigate his complaint and failed to act in accordance with the early resolution settlement that was agreed with the Ombudsman in November 2018.

The investigation found that the Health Board acted in accordance with the early resolution settlement that had been agreed with the Ombudsman in November 2018. As a result, the Ombudsman did not uphold this aspect of Mr B's complaint. The investigation also found that there was an appropriate standard of communication between the different specialists involved in Mr C's care. However, the Ombudsman found that the clinicians involved in Mr C's care did not provide Mr C with copies of the correspondence written to other clinicians. The Ombudsman concluded that this caused Mr C an injustice as it adversely affected Mr C's understanding of the clinical reasoning behind the different clinicians' opinions of his condition. As a result, the Ombudsman upheld this aspect of Mr B's complaint.

The Ombudsman recommended that the Health Board apologise to Mr C for the failing identified, share the report with the relevant clinicians and remind them of the relevant guidance on sharing correspondence written to other clinicians with the patient.

Swansea Bay University Health Board – Health
Case Number: 201903310 - Report issued in September 2020

Mrs X complained about her removal from the waiting list for hip replacement on 13 December 2017, that she did not have an appointment for her hip problem between 13 December 2017 and 29 August 2019, and that there was a significant breach of the Welsh Government's referral to treatment times ("RTT") guidelines. Mrs X paid privately for a total hip replacement at a private hospital on 29 August 2019.

The Ombudsman's investigation found that Mrs X's removal from the waiting list in December 2017, while belated, was reasonable, on the basis that her Consultant at the time had noted she wished to avoid a hip replacement, so she should not have been on the active list. Mrs X was then correctly reinstated anew to the waiting list in January 2019. Between January and August 2019 there was therefore no breach of the RTT guidelines. Nevertheless, the Ombudsman did find a service failure in that Mrs X had not been seen by any consultant between December 2017 and August 2019. A lack of clear communication with Mrs X had also led her to believe she was on the active waiting list from December 2017 when she should not have been. This communication failing was also a service failure and the Ombudsman partly upheld Mrs X's complaint. Having reflected on matters during the investigation the Health Board apologised and offered £250 to Mrs X for the poor communication.

The Health Board agreed to implement the Ombudsman's recommendations which were:

a) Within 1 month to make a redress payment of £500 to Mrs X in recognition of the failings and her time and trouble in pursuing the complaint (inclusive of the £250 it had already offered).
b) Within 6 months to review whether its waiting list administration department should record conversations with patients enquiring about their waiting times.

Not Upheld

Cardiff and Vale University Health Board – Health
Case Number: 201903273 - Report issued in September 2020

Dr A complained about his care and management following an admission to University Hospital Llandough for a laparoscopic (keyhole) operation to remove his gallbladder. His concerns were that there was a failure to convert the operation to open surgery when well-known but not common anatomical variations were encountered. He said that the surgery was carried out without a plan for overnight stay. Dr A said that his discharge was unsafe, and the post discharge advice given to him added to his further distress and clinical complications. Finally, Dr A was dissatisfied with Cardiff and Vale University Health Board's ("the Health Board's") complaint response as he was of the view that it was not robust, contained false,

misleading and contradictory statements and failed to address his concerns.

The Ombudsman's investigation concluded anatomic variations are common in gall bladder surgery and this is not an indication for conversion to open surgery. The Ombudsman was satisfied that, had there been a clinical indication that Dr A needed an overnight stay, this would have been arranged. The Ombudsman was also satisfied that Dr A's discharge was reasonable and appropriate and found no reason to conclude that Dr A's discharge was unsafe or that the advice given to him caused him harm. The Ombudsman did not uphold these aspects of Dr A's complaint.

In relation to Dr A's concerns that the Health Board's complaint response was not robust and contained false, misleading and contradictory statements and failed to address his concerns. The Ombudsman's investigation did not find any evidence to substantiate Dr A's concerns about the Health Board's complaint response and did not uphold this aspect of Dr A's complaint.

Early Resolution or Voluntary Settlement

A dental practice in the area of Aneurin Bevan University Health Board – Health
Case Number: 202000704 - Report issued in July 2020

Mr X complained that the Practice had not provided a complaint response in relation to his complaint about the way he was treated by the Practice. Mr X said that following his letter of complaint he received a deregistration letter from the Practice which did not address the concerns he had raised.

During his enquiries, the Ombudsman establish that the Practice had failed to address Mr X's concerns in its deregistration letter. In settlement of Mr X's complaint the Practice agreed to complete the following:

Within 4 weeks of the Ombudsman's decision letter:

a) Provide Mr X with an apology for the failure to adequately address his concerns
b) Provide Mr X with an explanation for this oversight

Provide Mr X with a complaint response.

Cardiff Council - Education
Case Number: 201906772 - Report issued in July 2020

Ms X complained about the Council's decision to stop her enrolling on a course at the Severn Road Adult Education Centre run by Cardiff Council ("the Council"). Ms X said that the Council's complaint response was inaccurate, failed to provide detail about the incident and was a misrepresentation of her character.

The Ombudsman concluded that the Council's complaint response did not provide an adequate explanation for the decision. The Ombudsman further concluded that there was no evidence to show that an assessment had been undertaken as outlined in the Council's "Health and Safety at Work" or any steps taken under its "Unacceptable Actions by Customers" policies had been followed in reaching the decision to exclude Ms X.

Following the Ombudsman's enquiries, the Council agreed the following:-

1) To, within 20 working days, reconsider the decision in accordance with the Council's "Health and Safety at Work" policy and "Unacceptable Actions by Customers" policy.
2) To, within 10 working days of the outcome of those enquiries, provide to Ms X:

    a) a written response/explanation for the decision

b) an apology for the Council's failure to act in accordance with its policies.

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

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

Case Number: 202000497 - Report issued in July 2020

Mr S complained about the length of time that Cardiff Community Housing Association ("CCHA") was taking to address his concerns about various maintenance issues which he first raised 12 months ago.

The Ombudsman was concerned that CCHA had failed to take any action to attempt to resolve Mr S's complaints.

In response to these concerns CCHA agreed to undertake the following actions, and in preparation a site visit has already been undertaken:

a) Undertake a full review of all Mr S's concerns
b) To address the health and safety issues surrounding the electric meter/isolation switch
c) Apologise to Mr S for the length of time taken to address his complaints
d) To pay Mr S the sum of £50 in recognition of the time and trouble taken to make his complaint

A Nursing Home in the area of Cardiff and Vale University Health Board - Independent Health Providers

Case Number: 202001681 - Report issued in August 2020

Mrs X complained that the Nursing Home had not provided a complaint response in relation to her complaint about the care provided to her late husband and the treatment of family members.

During his enquiries, the Ombudsman established that the Nursing Home had not acknowledged or provided a complaint response to Mrs X. In settlement of Mrs X's complaint the Nursing Home agreed to complete the following:

Within two weeks of the Ombudsman's decision letter:

a) Provide Mrs X with an apology for the failure to acknowledge her complaint and for the delay in providing a complaint response
b) Provide Mrs X with an explanation for the oversight and delay
c) Provide Mrs X with a complaint response.

Newport City Council - Various Other

Case Number: 202001634 - Report issued in August 2020

Mr X complained about the way he was spoken to by a member of staff at the Council, when he telephoned to raise concerns about care provided to his late mother. Mr X also complained that the telephone conversation had not been recorded by the Council.

During his enquiries, the Ombudsman established that the Council had failed to escalate Mr X's complaint to Stage 2, despite a request to do so. In settlement of Mr X's complaint the Council agreed to complete the following:

Within 4 weeks of the Ombudsman's decision letter:

a) Provide Mr X with an apology for failing to escalate his complaint to Stage 2

b) Provide Mr X with a Stage 2 complaint response.

Cardiff Council - Roads and Transport
Case Number: 202001327- Report issued in August 2020

Mr X complained that the Council had not provided a complaint response in relation to his complaint about road restrictions for Heavy Goods Vehicles.

During his enquiries, the Ombudsman established that since Mr X made his complaint to the Ombudsman, the Council had issued its complaint response. However, the Ombudsman found that the complaint response had been delayed with no meaningful updates being provided to Mr X during the course of the Council's investigation. In settlement of Mr X's complaint the Council agreed to complete the following:

Within two weeks of the Ombudsman's decision letter:

a) Provide Mr X with an apology for the failure to provide meaningful updates and for the delay in issuing the complaint response
b) Provide Mr X with an explanation for this oversight and the delay.

Denbighshire County Council - Environment and Environmental Health
Case Number: 202000968 - Report issued in August 2020

Mr B complained about Denbighshire County Council's ("the Council") decision to rescind its decision to offer him a meeting, stating the reason for the cancellation was due to current restrictions caused by Coronavirus.

The Ombudsman was concerned that the decision was unfair and denied Mr B the opportunity to discuss his ongoing areas of concern.

In response to these concerns the Council agreed to undertake the following action to resolve the matter:

a) As soon as the current lockdown restrictions allow, to arrange a meeting to discuss Mr B's areas of concern

Cardiff Council - Planning and Building Control
Case Number: 202002068 - Report issued in September 2020

Mr X complained that the Council had not followed its complaints procedure in relation to his complaint about a school perimeter fence being built backing on to his Close.

During his enquiries, the Ombudsman established that while the Council had responded to Mr X's concerns, his complaint had not been considered under the corporate complaints procedure. In settlement of Mr X's complaint the Council agreed to complete the following within four weeks of the Ombudsman's decision letter:

a) Provide Mr X with an apology for the failure to consider his complaint under its corporate complaints procedure
b) Provide Mr X with an explanation for this oversight
c) Provide Mr X with a complaint response.

Charter Housing Association (Part of the Pobl Group) - Housing
Case Number: 202001424 - Report issued in September 2020

Ms X complained that the Association had failed to respond to her complaint about her garden and repairs to her home which she made to it on 21 March 2020.

Although the Association had been in contact with Ms X in respect of these concerns, they had not been logged as a formal complaint, it agreed to complete the following in settlement of Ms X's complaint:

By 21 September 2020:

a) Apologise to Ms X for the delay caused in not logging her concerns as a complaint.
b) Investigate Ms X's concerns under stage one of its complaints procedure and issue a response.

Education

Early Resolution or Voluntary Settlement

Bridgend County Borough Council - School Transport
Case Number: 201907609 – Report issued in July 2020
Mr X complained about a lack of response from the Council about his daughter's school transport and how her school had facilitated her statement of needs.

The complaint had been raised via a separate body in October 2019 and Mr X contacted the Ombudsman expressing dissatisfaction at a lack of response. He considered that his daughter, and her schooling, had been discriminated against by the Council.

The Ombudsman found that he could not achieve anything further for the substance of the complaint as there were more appropriate bodies to consider the concerns but found that the delay had left Mr X in a position of not having a response to his concerns.

The Ombudsman resolved the complaint on the basis of an apology, a formal response to Mr X within a month and to meet with him (in accordance with any social distancing guidance) to discuss his concerns.

Pembrokeshire County Council - Special Educational Needs (SEN)
Case Number: 201907410 - Report issued in September 2020
Mrs A complained that the Council did not follow its own Compliments and Complaints Policy ("the Policy") when it deferred part of her complaint to a school within its area for investigation. Mrs A also complained that the Council did not act in accordance with the Policy when it notified the School of the complaint, of its decision to defer and its expectation that the School would respond directly to her. Furthermore, Mrs A complained that the Council did not investigate or address each aspect of her complaint within its complaint response.

The Council accepted that it did not act in accordance with the Policy and despite Mrs A requesting a formal investigation, it only undertook a Stage 1 informal investigation. In addition, the Council acknowledged that there should have been clearer communication with the School at the earliest opportunity and that a discussion could possibly have been held about the 3 issues earmarked for the School to investigate to be included within the Council's own complaint response.

The Council agreed to provide a written apology to Mrs A for the failings it identified within its complaint handling, make a redress payment of £250 in recognition of the failings and her time and trouble in making the complaint to the Ombudsman, review and revise the Policy and complete a Stage 2 investigation in response to the formal complaint Mrs A made to the Council in June 2019.

Admissions Appeal Panel for a School in the area of Torfaen County Borough Council - Admissions

procedures and appeals
Case Number: 202001813 - Report issued in September 2020
Ms S complained about the Admissions Committee's decision to refuse admission to the School for her child, T. The Admissions Committee said that admitting T to the School would "potentially adversely affect current teaching staff's capacity to plan, resource and support an additional pupil in classes". The School Admissions Code states that refusing admission on these grounds is only acceptable when the admission applications outnumber the places available. However, the School was not oversubscribed, and T met its admission criteria.

The Admissions Committee agreed to apologise to Ms S and T, and to review the admission decisions of every other applicant in the same session to ensure the Admissions Policy had been applied fairly and appropriately. It also agreed that all members of the Admissions Committee would undertake relevant training within 6 months of the date of the Ombudsman's final decision notice.

The complaint was settled on this basis.

Admissions Appeal Panel for a School in the area of Torfaen County Borough Council - Admissions procedures and appeals
Case Number: 202001427 - Report issued in September 2020
Ms S complained about the Appeal Panel's decision to uphold the School's decision not to admit her child, T. The Appeal Panel's decision found that admitting T might prejudice the overall provision of efficient education or use of resources at the school. The School Admission Appeals Code states that refusing admission on these grounds is only acceptable when the admission applications outnumber the places available. However, the School was not oversubscribed, and T met its admission criteria.

The Appeal Panel agreed to convene a new panel to reconsider the appeal and to review the appeal decisions of every other applicant in the same session to ensure the Admissions Policy had been applied fairly and appropriately. The Appeal Panel also agreed that the Clerk and all members of the Appeal Panel would undertake relevant training within 6 months of the date of the Ombudsman's final decision notice.

The complaint was settled on this basis.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

Conwy County Borough Council - Refuse collection. recycling and waste disposal
Case Number: 202002093 - Report issued in September 2020
Ms X complained that there have been multiple incidents of non-collection of recycling from her property and the Council was failing to address the issue.

In considering Ms X's complaint the Ombudsman was concerned that the Council had not provided Ms X with a formal complaint response and had treated the non-collection as a service request only.

In settlement of the complaint the Council therefore agreed to the following: -

By 10 October 2020

a) Issue Ms X with an apology for the inconvenience the non-collection has caused her.

b) Provide Ms X with a formal complaint response detailing what will be done to prevent the non-collection from reoccurring.

Housing

Early Resolution or Voluntary Settlement

Newport City Council - Applications. allocations. transfer and exchanges
Case Number: 202000031 – Report issued in July 2020
Mrs X complained on behalf of Mr and Mrs Y. Mrs X said that Mrs Y, who is disabled, had registered with Newport Home Options over 10 years ago for a bungalow with a level access shower. She was concerned, however, that the most recent assessment was done in 2016 and the conclusion was that the property she currently resided in had unsatisfactory housing conditions which was adversely affecting the household and that her health and welfare were being adversely affected by her present accommodation and placed her at risk of serious harm. Mrs X considered that, to resolve the complaint, Mr and Mrs Y should be considered for a bungalow that met Mrs Y's needs. Mrs X was also dissatisfied with the way that the Council handled her concerns about this matter.

When the complaint was assessed, it was concerning that Mrs Y's current housing needs and level of priority were based on information that was not current. The Council agreed to (1) arrange a visit by a Home Options Officer to assess the difficulties that Mrs Y was experiencing, (2) arrange an up to date occupational health assessment of (i) Mrs Y's current level of need/priority and (ii) the suitability of/possible adaptations required for her current property and (3) consider arranging for the case (level of priority) to be reviewed by the Health and Welfare Needs Assessment Panel. In fairness to the Council, elements of the settlement had been offered during the local resolution process. It was not considered that there would be merit in solely investigating the complaint handling issue given that the substantive complaint was being settled and the time taken to respond to Mrs X's complaint had not been unreasonable.

Bro Myrddin Housing Association - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202001676 - Report issued in September 2020
Mr F complained that Bro Myrddin Housing Association ("the Housing Association") had failed to complete necessary repairs to the windows in his property. In October 2019 an inspection was carried out which confirmed that Mr F's windows required repair or replacement. Mr F approached the Ombudsman in July 2020 because this work had not yet been started.

It agreed to carry out these actions by 5 October 2020, although at the time the case was closed it had already replaced Mr F's windows.

NHS Independent Provider

Early Resolution or Voluntary Settlement

Wrexham County Borough Council - Care homes
Case Number: 202000493 - Report issued in August 2020
The Council commissioned Mr X's father's ("Mr Y") care at a Care Home ("the Home"). Mr X was concerned about a number of incidents at the Home, the most serious one related to Mr Y's fall in April 2020. Mr Y was admitted to hospital; he had broken his hip. Due to the situation at the time with Coronavirus, Mr X was unable to visit Mr Y at the hospital or the Home which caused the family distress.

Mr X indicated the distress was compounded by poor communication from the Home about Mr Y's condition and the lack of clear explanation by the Home about how Mr Y fell. Mr X disputes the explanation provided by the Home about the fall.

While Mr X complained to the Home in the first instance about Mr Y's care, when he told the Council he was unhappy with the response and wished to escalate his complaint, the Council failed to provide him with the relevant complaints information. Had it done so, this would have identified that the next step would have been for the Council to commission a stage 2 independent investigation of Mr X's outstanding complaints (in accordance with the social services complaints procedure).

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

1) Apologise in writing to Mr X that he did not receive the relevant complaints information and provide him with this material.
2) Appoint an Independent Investigator to carry out a stage 2 investigation of Mr X's complaint in accordance with the statutory social services complaints procedure.
3) That the Independent Investigator contacts Mr X to agree the investigation definition.

Social Services – Adult

Early Resolution or Voluntary Settlement

Cardiff Council - Services for People with a disability inc DFGs
Case Number: 201906728 - Report issued in September 2020

Mr A had been receiving support from Cardiff Council's ("the Council's") Social Services since 2009 to assist with eligible needs arising from his health conditions. In August 2017, he raised 89 complaints about matters dating back to 2013. These were the subject of an independent investigation under stage 2 of the statutory social services complaint procedure, concluding in December 2018. Mr A complained to the Ombudsman about the time taken by the Council to investigate his concerns, and about the Council's failure to provide timely and appropriate remedy for the service failings identified.

The Ombudsman declined to investigate the substantive complaint issues in view of the thorough and robust investigation that had already been carried out. However, he considered that the findings raised significant concerns at an administrative level, and more widely in terms of how effectively the Council had met its obligations under the Human Rights Act 1998.

The stage 2 investigation found that the Council failed to follow the correct administrative process before reducing Mr A's care package, giving rise to significant uncertainty around whether it met his assessed and eligible support needs from at least 9 March 2016. After January 2017, there were occasions when the Council failed to fulfil its statutory duties towards Mr A, and he was left without care. At these times, he was exposed to potential harm and generally living with very little quality of life. The Ombudsman considered that the Council had also failed to consider the impact of these changes on Mr A's dignity, his ability to live independently, and to exercise choice and control, engaging his Human Rights under Article 8 (respect for home, private and family life).

The investigation also found that the Council had behaved in a way that was procedurally unfair to Mr A by not providing him with enough information to understand the basis of the changes that were made to his care package, or to be able to challenge them. The Ombudsman considered that this was enough to engage Mr A's Human Rights under Article 6 (right to a fair hearing, linked to due process).

Finally, in addition to historical failings to advise Mr A of his right to complain, and to investigate his complaints when he made them, the Council overly delayed responding to some of the preliminary findings of the stage 2 investigation, meaning that opportunities were lost to put mattes right as soon as possible. When the Council did respond, it did not acknowledge or offer sincere apologies for many of the significant failings identified. Further, it did not fully recognise the impact of those failings on Mr A.

The Ombudsman was very critical of what happened in this case and asked the Council to undertake the following, to which it agreed, in settlement of the complaint:

a) Taking into account the Scottish Public Services Ombudsman's Guidance on Apology, and the Public Services Ombudsman for Wales' Principles for Remedy, issue a further, meaningful apology to Mr A that takes full responsibility for the failings in this case, that recognises why an apology is needed, and acknowledges the impact of the failings on him.
b) Make a redress payment of £7000 to Mr A in recognition of the uncertainty around the reductions in his care package from March 2016 and the gaps in provision after January 2017.
c) Make a further redress payment of £1000 to Mr A in recognition of the historical failure to investigate his complaints, the failure to put ongoing service issues right at the earliest opportunity in March 2018, and the inadequate response to the stage 2 investigation findings in December 2018.
d) Demonstrate organisational learning from the complaint by sharing the key findings from the stage 2 investigation, and the Ombudsman's settlement decision (by whatever means the Council deems appropriate) with all social workers, managers and complaint handlers.
e) The Council's Equality and Human Rights Team to consider further how human rights considerations can be embedded into social work practice.

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

Case Number: 201907197 - Report issued in September 2020

Broadly, Mr and Mrs A complained that after their complaints went through stage 2 of the Social Services Complaints Procedure, Ceredigion County Council ("the Council") failed to put in place the agreed actions. They said that in December 2019 they met with senior officers who drew up a list of outstanding actions but these had not been addressed. They said that they and their son, Mr B, had suffered hardship and injustice because of this.

The Council agreed to take a number of steps to settle the complaint. It agreed to apologise for failing to implement the accepted recommendations and lack of substantial progress made; to arrange for a mutually acceptable independent person to oversee a resolution meeting; to appoint a suitable senior officer to oversee the implementation of the action plan; to consider the current position (in respect of the safeguarding complaint), in light of apparent delay in implementing the latest care plan, and determine whether a safeguarding referral was appropriate; to carefully reconsider how Direct Payments should be arranged; to resolve, with the complainants' input, the respite care issue; to appoint a care plan co-ordinator and update the care plan and to offer to record all meetings with the complainants, with their permission, and retain those recordings for an appropriate period of time. The Council agreed to undertake these actions within 2 months subject to any issues being considered by the resolution meeting possibly taking longer to address.

Rhondda Cynon Taf County Borough Council - Services for older people

Case Number: 202001479 - Report issued in September 2020

Mr A, on behalf of Mrs B, complained about the standard of the recent care and support services being received by Mrs B from Rhondda Cynon Taf County Council ("the Council"). Mr A said that the Council was refusing to engage with Mrs B regarding her concerns. He also complained about the most recent

reassessment process.

The Ombudsman contacted the Council as he was concerned that the Council's complaints procedure had not been exhausted in relation to the matters complained about. The Council agreed to carry out a formal investigation at Stage 2 of its Social Care Comment and Complaints procedure.

Social Services – Children

Early Resolution or Voluntary Settlement

Flintshire County Council - Safeguarding
Case Number: 202001361 - Report issued in September 2020
Ms A complained about the Council's handling of her safeguarding concerns and reports of injuries sustained by her child at school. She complained about the Council's failure to undertake a child protection investigation under Section 47 of the Children Act 1989, which Ms A considered to be a breach of the All Wales Child Protection Procedures. Ms A also complained about the Council's response to her complaint, and about the content, accuracy and conclusions of the Independent Investigation Report. Ms A sought a full investigation and a satisfactory response, explanation and apology.

The Ombudsman concluded that, whilst the Council's decisions appeared reasonable, an appropriate explanation had not been provided to Ms A. There was evidence of poor record-keeping and the Council had not implemented some of the recommendations in of the independent investigation report.

The Council agreed to, within 20 working days, provide Ms A with an apology for its failure to record a referral and an interview, and an explanation of how the Council reached its decision that Child Protection Procedures were not applicable, why it considered that the threshold for a Section 47 investigation was not met and for its misleading information contained in correspondence. The Council also agreed to consider, in conjunction with Ms A, the matters she considered to be incorrectly recorded in the Investigation Report and, if appropriate to prepare an addendum report rectifying any discrepancies.

The Ombudsman's view was that the above action was reasonable to settle Ms A's complaint.