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PUBLIC SERVICES OMBUDSMAN FOR WALES

The Ombudsman's Casebook

Issue 43 October – December 2020

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Public interest report issued: complaint upheld

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905373 - Report issued in December 2020
Mr Y complained that the Health Board exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer and that due to the delay in providing him with treatment, and the potential impact of any delay, he sought private treatment.

The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules") at the time of the events complained about stated that: "Newly diagnosed cancer patients that have been referred as urgent suspected cancer, and confirmed as urgent by the specialist to start definitive treatment within 62 days from receipt of referral …"

The Ombudsman found that the Health Board would have missed the RTT Rules timescale in Mr Y's case by at least 106 days taking into account the estimated waiting times at the time of Mr Y's diagnosis (3 months). Considering the professional advice that early radical treatment was essential in high-risk disease, a 3 month wait for definitive treatment was unacceptable regardless of the RTT Rules. This was a service failure.

In Mr Y's case, the delay for treatment, and concern about the potential impact on his clinical condition from any delay, led to his decision to seek private treatment. The delay, well in excess of the 62-daytarget in Mr Y's case, caused him significant distress and anxiety, and his decision to seek private treatment sooner (rather than wait for the Health Board to provide treatment) did not lessen the impact of the Health Board's service failure on Mr Y at a very worrying time. At the time Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. This was an injustice to Mr Y. The complaint was **upheld**.

The Health Board agreed to the Ombudsman's recommendations that, within **6 weeks** of the date of the final report, the Health Board should:

1. Provide Mr Y with a fulsome written apology for the failing identified in this report.
2. Make a redress payment of £8,171 to Mr Y to represent the cost of his private treatment.

The Health Board agreed to the Ombudsman's recommendation that, within **4 months** of the date of the final report, the Health Board should:

3. Refer the report to the Board and ask it to set up a Task and Finish group to review the Urology service to identify where it can improve service delivery, in particular in relation to cancer treatment targets, to ensure that patients'(particularly high-risk patients) care and treatment is not compromised.

Covid

Early Resolution or Voluntary Settlement
Rhondda Cynon Taf County Borough Council - Finance and Taxation

Case Number: 202002004 - Report issued in October 2020

Ms X complained that she had been having financial difficulties for a number of years and had an arrangement with the Council to pay her Council Tax arrears. Her income was further affected by lockdown, due to the COVID-19 pandemic, as she was required to shield. She contacted the Council to discuss her financial situation. The Council placed a Liability Order on her home.

The Ombudsman discovered that the Council had investigated Ms X's complaint under Stage 1 of its complaints process but it had not informed her how to escalate her complaint should she be dissatisfied with its outcome.

The Council agreed to apologise for this failure and to immediately escalate Ms X's complaint to Stage 2 of its complaint process.

Tai Calon Community Housing – Housing

Case Number: 202002674 - Report issued in October 2020

Mrs X complained that Tai Calon Community Housing ("the Association") had failed to replace her broken window and after two months could still not provide her with a date when the repair would be completed.

In making enquiries with the Association the Ombudsman was informed that due to the current pandemic there had been delays with the suppliers which meant the window could not be replaced. However, it also became clear that despite sending the Association a formal complaint, Mrs X's had not received a response in line with the complaints process. The Ombudsman considered this to be a service failure on the part of the Association and it therefore agreed to complete the following actions in settlement of Mrs X's complaint:

By 30 October 2020

a) Apologise to Mrs X for failing to formally lodge her complaint
b) Provide Mrs X with a full response to her complaint detailing what efforts have been made to repair the window and when the repair is likely to take place.

A GP Practice in the area of Hywel Dda Health Board - Health

Case Number: 202002502 - Report issued in November 2020

Ms A complained that since the COVID-19 pandemic, she had been unable to access GP services. This was mainly because her telephone was unable to accept calls from withheld numbers.

The Ombudsman contacted the Practice, as he was concerned about Ms A's lack of access to GP services over a 7 month period, the resulting effects and that she needed an urgent GP review.

The Practice agreed to formally consider and write to Ms A to confirm what reasonable adjustments, in accordance with the Equality Act 2010, could be made to ensure she could access its services. It also agreed to provide Ms A with a formal complaints response.

Hywel Dda University Health Board - Health

Case Number: 202002115 - Report issued in November 2020

Ms A complained that since the COVID-19 pandemic, she had been unable to access secondary care services. This was mainly because her telephone was unable to accept calls from withheld numbers.

The Ombudsman contacted Hywel Dda University Health Board ("the Health Board"), as he was concerned about Ms A's lack of access to services over a 7 month period.

The Health Board agreed to formally consider and write to Ms A to confirm what reasonable adjustments, in accordance with the Equality Act 2010, could be made to ensure she could access its services. It also

agreed to investigate any new concerns in accordance with Putting Things Right.

Health

Upheld

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905601 - Report issued in October 2020

Mr D complained that the Health Board failed to diagnose Down's Syndrome in his daughter (L) until she was 11 months old. He said that his daughter was seen by numerous clinicians who failed to identify early signs of Down's Syndrome.

The Ombudsman found that the clinicians who examined L in the first 6 months of her life carried out appropriate assessments which had not shown abnormalities which might have raised suspicions of Down's Syndrome. The Health Visiting service made an appropriate referral to the Community Paediatric team after developmental concerns and abnormal facial features were identified at L's 6 month review. The Ombudsman found that a Community Paediatrician who saw L in August 2018 had suspicions of Down's Syndrome but had not informed the family or sought to make a diagnosis until after a follow up appointment 3 months later. The Ombudsman upheld the complaint on the grounds that the delay deprived Mr D and his wife of 3 months when they could have sought emotional support to help them come to terms with the diagnosis.

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

a) Within I month, apologise to Mr D and his wife, share the report with the Community Paediatrician and remind all paediatric clinicians of the importance of informing parents at the earliest appropriate opportunity when Down's Syndrome is suspected and to consult with colleagues in order to avoid delayed diagnosis.

Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 201903980 - Report issued in October 2020

Mr D complained about the care and treatment provided to his late wife ("Mrs D") by Swansea Bay University Health Board's District Nursing Service ("DNS") concerning a pressure ulcer, and the way the Health Board communicated with him. Mr D also complained about the way the Health Board handled his complaint.

The Health Board acknowledged at the outset of the investigation that there had been shortcomings in its communications with Mr D and the way it handled his complaint, which is an injustice to him. The Health Board offered to apologise to Mr D for the failings and to make financial redress. Therefore, these elements of the complaint were **upheld**. The Ombudsman's investigation also found that Mrs D's wound was not appropriately monitored or managed, there was a lack of care planning which might have made Mrs D's admission to hospital more unlikely, and a lack of continuity in care delivery which contributed to poor communication with Mr D. This caused anxiety, distress, concern and inconvenience for Mr and Mrs D and was an injustice. Therefore, this aspect of the complaint was also **upheld**.

The Health Board agreed (within 6 weeks of the Ombudsman's decision) to apologise for the failings identified, to pay Mr D £500, to improve referral processes and to share the final report with relevant clinical staff for critical reflection. The Health Board also agreed (within 3 months of the Ombudsman's decision) to review current practices with the DNS to ensure compliance with policies and practice in relation to wound assessment, care planning and collaboration with patients and carers.

A GP Surgery in the area of Powys Teaching Health Board - Clinical treatment outside hospital

Case Number: 201902258 - Report issued in October 2020

Mrs Y complained about the care and treatment that was provided to her late father Mr X. Mrs Y said that there had been a failure to appropriately investigate, manage and diagnose Mr X's leg pain from April 2018 onwards (as it was later found that Mr X had peripheral vascular disease - "PVD" - a build-up of fatty deposits in the arteries that restricts blood supply to the legs). In addition, Mrs Y said that there had been a failure to appropriately investigate Mr X's voice and chest symptoms, which led to the missed diagnoses of bronchopneumonia (a type of pneumonia that causes inflammation of the alveoli (tiny air sacs in the lungs) and lung cancer).

The Ombudsman found that Mr X's leg pain was musculoskeletal in nature and the respective GPs undertook investigations and sought help from appropriate specialities. This complaint was not upheld.

The Ombudsman found two failings in clinical care; a missed opportunity for a referral for a chest X-ray and a missed opportunity for a discussion to be held around admission to hospital. Whilst these failings would not have altered the clinical outcome for Mr X, an earlier diagnosis would have allowed for additional pain relief to be prescribed as well as end of life care. In addition, Mr X and the family would have had time to prepare. This aspect of the complaint was upheld.

The Surgery agreed to provide Mrs Y with an apology for the failures identified, to reflect on the failings and discuss the case as part of a Significant Event Analysis.

Betsi Cadwaladr University Health Board & Betsi Cadwaladr University Health Board and a GP Practice in the Health Board area - Clinical treatment in hospital

Case Number: 201906748 & 201907143 - Report issued in October 2020

Ms B complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to provide her late father Mr C, with appropriate care and treatment. Specifically, Ms B complained that there was a delay in the Health Board diagnosing and treating Mr C's cancer.

Ms B also complained about a GP surgery in the area of the Health Board ("the Surgery"). Specifically, Ms B complained that the Surgery failed to provide her father with appropriate care and treatment.

The Ombudsman did not uphold the complaint against the Surgery. He found that the Surgery undertook appropriate and timely tests and investigations into Mr C's symptoms and that the care provided fell within the bounds of appropriate clinical practice. The Ombudsman's investigation also found that the Surgery completed appropriate referrals in line with relevant clinical guidance, and that there was not a delay or missed opportunity in the diagnosis of Mr C's cancer. As a result, the Ombudsman did not uphold the complaint. However, it was noted that the Surgery failed to re-examine Mr C during a consultation and failed to provide him with safety netting advice during a number of consultations in 2017. The Ombudsman suggested that the Surgery considered his comments and brought them to the attention of its clinical staff.

The Ombudsman upheld the complaint against the Health Board to a limited extent. The Ombudsman's investigation found that there was a 15 day delay in suspicious findings being identified on a scan. He found that the identification of suspicious findings on the first report of the scan, undertaken on 20 December 2017, may have allowed earlier treatment for Mr C's cancer-related symptoms and therefore reduced his and his family's distress. He also found that earlier identification would have given Mr C and his family more time to come to terms with Mr C's diagnosis. The Ombudsman concluded this was an injustice as it caused avoidable distress and anxiety to Mr C and his family.

The Ombudsman recommended that the Health Board apologised to Ms B and offer her a payment of £500 in recognition of the distress caused by the failings identified. He also recommended that the Health Board shared the report with the clinicians involved in Mr C's care, in particular the Radiology Department, and confirmed to the Ombudsman that the report had been used for critical reflection.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201902057 - Report issued in October 2020

Ms A complained about the care she received when she was admitted to hospital between 24 January and 12 February 2018 with severe confusion and agitation. She said that Hywel Dda University Health Board ("the Health Board") failed to adequately manage her risk of falls, diagnose and treat her shoulder injury promptly and appropriately, inform her of the nature of her injury and treatment options and ensure that she was discharged safely.

The Ombudsman found that Ms A was not asked whether she wanted supervision while she was using the commode. This led to uncertainty whether Ms A would have wanted someone with her and, therefore, whether Ms A's unwitnessed fall from the commode could have been prevented. However, it did not appear that the fall was the cause of Ms A's shoulder injury.

The Ombudsman also found failures to report fully on radiological images of Ms A's shoulder injury and to obtain further images to investigate the extent of it. As a result, Ms A's shoulder fracture and dislocation was not accurately diagnosed and could not have been considered in decisions about Ms A's care plan or communicated to Ms A. Furthermore, no attempt was made to ensure that Ms A was fully informed about the nature of her injury and her treatment options during her admission, even after her confusion had resolved. In addition, Ms A was not given adequate information on how to care for her injury or where to seek support once she was home, and an identified need for community support was not confirmed with the relevant authority.

The Ombudsman upheld Ms A's complaints and recommended that she should be offered an apology and £1,000 financial redress. He also recommended that all relevant staff should be reminded of appropriate clinical standards and that the clinicians involved should reflect on his findings in order to take learning from the events. He also recommended that the Health Board issue guidance on what steps should be taken in the event that a patient's capacity is compromised, or fluctuating, to ensure that they are informed and involved when decisions are being made about their care. Finally, the Ombudsman recommended that the Health Board review its discharge process to ensure that ongoing management and post-discharge information given to patients is recorded, and to improve provision of a joined-up service when community care is required.

Swansea Bay University Health Board - Appointments/admissions/discharge and transfer procedures
Case Number: 201904061 - Report issued in October 2020

Miss X complained whether 2 May 2018 was the appropriate date that she was placed on the waiting list for hip surgery and there was a significant breach of the Welsh Government's referral to treatment times ("RTT") target for treatment. Miss X paid privately for treatment at a private hospital on 16 March 2020. The Ombudsman's investigation found that Miss X was appropriately placed on the waiting list for treatment on 2 May 2018. In January 2019 Miss X was placed on the expedited urgent waiting list and in November, a metal ion test showed a reduction in Miss X's chromium and cobalt levels.

The Health Board said that Miss X's revision surgery was urgent, but she was not of a higher clinical priority than others on the urgent waiting list.

The Health Board did not inform Miss X that the elective Orthopaedic Ward's capacity was lost to emergency admissions. It was found that there was a breach of the RTT, but given that Miss X's condition had not deteriorated and her care was not to be expedited, there was no injustice. However, the Ombudsman found that the Health Board had not appropriately communicated with Miss X, she was not informed of the November test results or that her care was not to be expedited. The Ombudsman upheld this aspect of the complaint.

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

a) Within 1 month, to apologise and make a redress payment of £500 to Miss X in recognition of the failings and her time and trouble in pursuing the complaint.
b) Within 6 months, to review the situation on the Orthopaedic Ward (before the COVID pandemic) and inform the Ombudsman of the effectiveness of steps put in place to reduce waiting times.
c) Review whether GPs and patients awaiting orthopaedic procedures should be informed when things are likely to return to normal.

A GP in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201901909 - Report issued in October 2020

Mrs A complained about the care given to her daughter, B, by a GP ("the GP") in the area of Betsi Cadwaladr University Health Board. She said that the GP had not assessed B's chest condition thoroughly, that she had prescribed an inappropriate steroid inhaler for B, that she had given her a delayed antibiotic prescription for B and that she had not given her any advice about when to give B that antibiotic. Mrs A also said that the GP had blamed her for the deterioration in B's condition when responding to her complaint.

The Ombudsman found that the GP had not examined B's chest fully, that the steroid inhaler and antibiotic prescriptions that the GP had given to Mrs A for B had been inappropriate, and that the GP had not given Mrs A appropriate safety-netting advice. He accepted that B had not suffered any harm because of these failings and recognised that the injustice caused to Mrs A, which took the form of distress, concern and anxiety, was limited. He partly upheld the assessment element of Mrs A's complaint and upheld the prescription and advice aspects of it. He did not uphold the complaint response part of Mrs A's complaint.

The Ombudsman recommended that the GP should write to Mrs A to apologise for the clinical failings identified. He asked the GP to undertake some Continuing Professional Development activity related to the diagnosis and management of the chest condition that was diagnosed in B's case. He also recommended that the GP should arrange to discuss the clinical failings identified at her next appraisal. The GP agreed to implement these recommendations.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201901701 - Report issued in October 2020

Ms X complained, on behalf of her adult daughter Ms Z, that Ms Z was able to abscond from hospital in July **2018**, that Absent Without Leave procedures were not correctly followed, that communication with Ms X from June to December was poor, that Ms Z was inappropriately restrained and sustained bruising during the same period, and that there was a lack of support for Ms Z when she was discharged in December.

The Ombudsman found that Ms Z was able to abscond from hospital on an occasion when it should not have been possible, causing a significant injustice to this vulnerable and unwell young woman. Thereafter, the Absent Without Leave procedures were correctly followed. The complaint was therefore **partly upheld**. The investigation determined that generally, communication was reasonable, however there was a significant delay in Ms X speaking to the Consultant in June to July, and Ms X was not advised that Ms Z had absconded from hospital on a second occasion, therefore the complaint was **upheld**. The investigation **did not uphold** Ms X's complaint that Ms Z did not receive appropriate support prior to her discharge from hospital.

The Ombudsman found that Ms Z was inappropriately restrained on 2 occasions when she was taken to the floor without sufficient reason being recorded in the records. Further, no Care Plan for Restraint was available. The Ombudsman therefore **upheld** the complaint that Ms Z was inappropriately restrained and commented that the potentially disproportionate use of restraint, and its consequential impact on Ms Z's dignity, may have impacted on Ms Z's rights under Article 5 and Article 8 of the European Convention on

Human Rights.

The Ombudsman recommended that the Health Board should apologise to Ms X and Ms Z within 2 months of the date of the report. The Ombudsman also recommended that within 6 months, the Health Board should consider amending its policy on leave, to ensure that leave is always underpinned by a current, clear and robust care plan.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201907593 - Report issued in November 2020

Mr and Mrs A complained that Cardiff and Vale University Health Board ("the Health Board") inappropriately changed their son, B's tracheostomy tube. Specifically, they complained that the Health Board failed to use an appropriately sized tube as it relied upon B's height/age to determine the size rather than conducting appropriate investigations and an adequate assessment to determine the space available. They further complained that the Health Board failed to seek specialist advice from Great Ormond Street Hospital (GOSH) before changing the tube size, failed to obtain informed consent beforehand, failed to conduct appropriate investigations or provide accurate explanations in relation to B's subsequent breathing problems, and that its actions decreased B's life expectancy.

The investigation found that an appropriately sized tube was used and that it was appropriate to change B's tube size without prior investigations. It also found that it was not necessary to seek advice from GOSH before upsizing B's tube, that it was not necessary to obtain written and signed consent before changing it, as it was not an invasive procedure, and that appropriate investigations were conducted in relation to B's subsequent breathing problems. The investigation found that the change of tube was not the cause of the decrease in B's life expectancy. Investigations conducted after the procedure identified anatomical problems in B's chest which impacted upon his life expectancy. As such, these complaints were not upheld.

However, the investigation did find that the Health Board failed to provide Mr and Mrs A with adequate explanations on 2 occasions. This left Mr and Mrs A thinking that 2 hospitals were making different diagnoses and caused feelings of distrust. It also led to them not fully understanding the mechanism of B's intermittent breathing problems nor how to rectify them.

The uncertainty and distress caused was an injustice to them and contributed to them making the complaint. Therefore, this aspect of the complaint was upheld.

The Health Board agreed to apologise in writing to Mr and Mrs A for the failings identified and to share the investigation report with staff involved for reflection and learning to improve their future performance in relation to documenting conversations with a patient's family.

Swansea Bay University Health Board & Welsh Ambulance Services NHS Trust - Clinical treatment in hospital & Ambulance Services
Case Number: 201902910 & 201902909 - Report issued in November 2020

Mrs A complained about the care and treatment that her late mother, Mrs B, received from Swansea Bay University Health Board and the Welsh Ambulance Services NHS Trust. In particular she complained that the care and treatment provided to Mrs B by the Health Board was inadequate, it was inappropriate for the Health Board to discharge Mrs B home from hospital on 12 January 2019 and that the Trust failed to provide an ambulance for Mrs B within an appropriate timeframe on 13 January 2019 resulting in her mother's unnecessary death.

The investigation found that the treatment provided to Mrs B was appropriate but that the prescribing of laxatives should have been fully documented. The Ombudsman upheld this aspect of the complaint to that extent. The investigation did however, find that it was appropriate to discharge Mrs B on 12 January and that the Trust made reasonable efforts to try and reach her as soon as reasonably practicable within

the resources available on 13 January. These parts of Mrs A's complaint were therefore not upheld.

The Ombudsman recommended that, within 2 months, the Health Board apologises to Mrs A for the failings identified and shares his report with the GP involved as a tool for reflection and future learning.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905983 - Report issued in November 2020
Ms A complained about the care and treatment she received from Betsi Cadwaladr University Health Board in August to September 2019 following a miscarriage. In particular, Ms A complained that she did not have the opportunity to discuss her circumstances with a senior doctor, that there was no advice provided to her following the surgical management of the miscarriage ("SMM"), that an error occurred during the SMM which led to excessive bleeding, that the SMM failed to remove all tissue, that there was a delay in dealing with her excessive bleeding and a lack of communication with her about it, that she might have lost a second baby which might have been missed on her 12-week scan, and that she was left covered in blood in an Emergency Department on 12 September.

The Ombudsman found that overall, the level of communication and information provided to Ms A had been appropriate, but that there had been a missed opportunity for her to discuss her concerns with a senior doctor. He **upheld** those elements of Ms A's complaint on that limited basis. The Ombudsman found no evidence that an error occurred during the SMM or that a second baby had been missed on any of the scans performed by the Health Board. The Ombudsman found that bleeding and retained tissue following SMM are recognised risks and are not indicative of service failings, and that there was no delay or lack of communication in dealing with Ms A's bleeding. These elements of the complaint were **not upheld**.

The Ombudsman found that there had been a delay in the Health Board assisting Ms A to wash following a gynaecological procedure performed in the Emergency Department on 12 September and that this delay impacted on Ms A's dignity and human rights (Article 8). This element of the complaint was **upheld**. The Health Board agreed to apologise to Ms A within 1 month for the failings identified and to acknowledge the impact of the delay in assisting her to wash on 12 September.

It also agreed, within 3 months, to share the Ombudsman's report with relevant clinicians to facilitate learning, to remind relevant staff of the relevance of the Human Rights Act 1998 to their work, and to remind staff to provide cleaning facilities to patients and to remove surgical equipment if gynaecology procedures are undertaken in the Emergency Department.

Cwm Taf Morgannwg University Health Board - Clinical treatment outside hospital
Case Number: 201905949 - Report issued in November 2020
Mrs A complained about the District Nursing care provided by the Health Board to her late father, Mr B, who had Motor Neurone Disease. Mrs A complained that there had been a delay in providing appropriate continence products and training to her family, a failure to administer palliative care medication, a failure to check Mr B's bed sores, a delay in inserting a catheter, and poor record keeping. Mrs A also complained about an incident in which she said a District Nurse had shouted at her family.

The Ombudsman found that there had been a delay in the Health Board providing continence products to Mr B and that this delay impacted on Mr B 's human rights (Article 8), and Mrs A's human rights as his carer. The investigation found there had been no evidence to suggest that the Health Board had considered providing Mr B's family with an oral form of palliative medication which they could administer, and a lack of follow up to issues relating to palliative medication. The Ombudsman found that there had been a failure to assess risks to Mr B's skin on a weekly basis (which it should have done as a minimum), and that there was little engagement with Mr B and his family following an initial assessment regarding his urinary incontinence which led to a missed opportunity to engage the Health Board's Bladder & Bowel Team sooner. The Ombudsman also found several instances of poor record keeping. All of these

elements of the complaint were therefore **upheld**.

The Ombudsman obtained statements from parties present during the alleged incident in which a District Nurse had shouted at Mr B's family and found that while it was clear voices had been raised, there was insufficient evidence to suggest that the District Nurse shouted at Mr B's family. This element of the complaint was **not upheld**, but the Ombudsman suggested that the Health Board offer training on dealing with confrontation to its District Nursing Team.

The Health Board agreed to apologise to Mrs A for the failings identified within 1 month. It agreed that it would, within 3 months, share the Ombudsman's report with the District Nursing and Bladder & Bowel Teams to facilitate learning, develop an information pack for families caring for family members who require continence products, and to develop an action plan to address the failings identified by the Ombudsman. The Health Board also agreed to audit District Nursing records within 6 months to ensure that they were being completed in line with its own polices and relevant national guidance.

Hywel Dda University Health Board - Appointments/admissions/discharge and transfer procedures
Case Number: 201905578 - Report issued in November 2020
Mrs A complained about the care her late father (Mr B) was afforded and questioned: whether the decision to admit him under the Mental Health Act ("the MHA") 1983 was clinically appropriate, whether relevant legislation, policy and guidance was adhered to during the assessment, transfer and admission. Whether the communication with the family between the referral for re-assessment and the transfer taking place was adequate and whether the record keeping of the Community Psychiatric Nurse ("CPN") was appropriate.

The investigation found that the decision to admit Mr B under the MHA was clinically appropriate given the risk he posed to himself and others and that clinicians adhered to the relevant legislation and guidance when undertaking the assessment, planning transfer and admission.

The investigation found that whilst it appeared that attempts were made to communicate with the family, the communication was not effective and led to the family feeling shocked and confused on 2 and 3 August. The investigation was hindered by the poor record keeping of the CPN which the investigation found was contrary to the requirements of the NMC Code. The latter 2 aspects of the complaint were upheld.

The Health Board agreed to: apologise to Mrs A, prepare guidance for families on the overlapping purposes of the Mental Capacity Act and the MHA and when it is appropriate for an Independent Mental Capacity Advocate to be present during an assessment and to introduce a mechanism whereby if a family member is unhappy about a decision made for admission under the MHA there is an option for a broader family group conference to be held if there is time to do so.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201905620 - Report issued in November 2020
Mr C complained about the care he received in April 2017 when he was admitted for surgery to remove part of his bowel, and that his discharge was unsafe. He also complained that the original surgical team failed to communicate effectively and appropriately when he suffered post-operative complications and was re-admitted to another hospital in May and July 2017. In addition, Mr C complained that his request to access his medical records was not dealt with appropriately and in a timely manner.

The Ombudsman found that Mr C's original surgery was conducted appropriately and that his subsequent symptoms of infection were treated appropriately. However, there was inadequate consideration of the possibility of a leak at the original surgical site and so this complaint was partially upheld. He found that Mr C's discharge was safe but that Mr C should have been informed of what symptoms of post-operative complications to look out for. He should also have been given additional blood-thinning medication to

prevent blood clots and this omission raised uncertainty as to whether Mr C's subsequent blood clot could have been prevented. Therefore this complaint was upheld.

The Ombudsman found that it was reasonable for Mr C to remain under the care of the second hospital and that the Health Board had already reminded relevant staff of the benefits of direct communication with the original team when a patient presents elsewhere with post-operative complications. This element of the complaint was not upheld.

The Ombudsman also found that the Health Board failed to recognise Mr C's request to see his medical records as a formal information request and inappropriately asked him to make a further, separate request to a designated point of contact with proof of his identify. In addition, it did not provide him with his records within the relevant statutory timescales and did not keep him informed of the reasons for the delays. The Ombudsman upheld this complaint.

The Health Board agreed to apologise to Mr C and to share the Ombudsman's report with the staff involved for them to reflect on his findings. It also agreed to remind all relevant staff of guidance on prescribing extended courses of blood-thinning medication and on the importance of completing full and thorough discharge summaries. The Health Board also agreed to ensure all complaints handling staff were aware of the rights of individuals to make information requests. It agreed to complete these actions within 1 month.

The Health Board further agreed to review its policy on information requests to ensure that it was fully compliant with its statutory duties and to provide training to all relevant staff on how to identify and deal with such a request within 6 months.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201904219 - Report issued in November 2020

Mr X's complaint Advocate ("the Advocate") complained that Ysbyty Ystrad Fawr ("the Hospital") failed to investigate his swollen knee by X-ray to identify a meniscus tear (torn cartilage), and incorrectly attributed the swelling as a Baker's cyst (a fluid filled sac behind the knee). He complained that a GP Practice ("the Practice") within the Health Board area (and managed by the Health Board) referred him for X-ray but the result was not discussed, referral to an Orthopaedic Consultant was not timely, wait for surgery was excessive, and it was dismissed that pain medication may have masked the knee pain. Mr X also said that despite the Health Board knowing he cannot read, correspondence was sent to him and not the Advocate.

The Ombudsman found that Mr X's treatment at the Hospital was reasonable and the finding of a Baker's cyst at that time was appropriate. He found that when Mr X attended the Practice on 2 occasions he was appropriately firstly referred for an X-ray which had not shown any abnormality and then secondly, an ultrasound scan. He found that although Mr X was not informed of the outcome of the X-ray, he would have been informed at another appointment which he had not attended, despite uncertainty about a note being left to attend as Mr X could not read, it had not led to an injustice as orthopaedic referral was not indicated. The Ombudsman found that Mr X's referral to a specialist and treatment was appropriate. He found that Mr X had not had an excessive wait for treatment, and his pain medication was not dismissed. These aspects of the complaint were not upheld.

The Ombudsman found that Mr X signed a consent form for treatment, although he cannot read and, on this basis only, he upheld this aspect of the complaint. He also found that the Health Board should not have sent letters to Mr X. These aspects of the complaint were upheld.

The Health Board agreed to implement the Ombudsman's recommendations and apologise to Mr X (within 1 month), remind clinical staff that clinical letters should also document unsuccessful outcome of surgery and take measures to ensure patients can read before being asked to sign documents (within 3 months).

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201803785 - Report issued in November 2020

Ms C complained that Aneurin Bevan University Health Board had mismanaged the delivery of her late son, D, because it had not addressed her placenta (an organ attached to the lining of the womb which nourishes the unborn baby) retention risk properly or stopped her from developing maternal sepsis (sepsis occurs when the body overreacts to an infection and starts to damage organs and tissues). She said that the Health Board had not ensured that the cuddle cot (a special cooling unit that helps to preserve a deceased baby) provided for D was working properly. She also complained that the Health Board had not enabled her to obtain a "Certificate of Stillbirth" ("Stillbirth Certificate") because it had recorded D's gestational age (the estimated age of the unborn baby) incorrectly and that it had not completed a mortality review, in respect of him, despite indicating that it had done so.

The Ombudsman found that the Health Board had managed D's delivery appropriately. He could not establish that D's cuddle cot had not been working properly. He was satisfied that the Health Board had correctly determined D's gestational age when he died and accepted that it would have been inappropriate for Ms C to have had a Stillbirth Certificate as a result. He did not uphold the delivery, cuddle cot or Stillbirth Certificate parts of Ms C's complaint. He found that the Health Board had erroneously told Ms C that it had completed a mortality review in respect of D. He considered that that error had caused Ms C, in terms of unfulfilled expectations, an injustice. He upheld the mortality review aspect of Ms C's complaint.

The Ombudsman did not consider it appropriate to make any recommendations in response to his finding about the mortality review due to the nature of the failing identified and the apology already given to Ms C by the Health Board.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201806837 - Report issued in December 2020

Ms D complained about the care given to her late partner, Mr E, by Hywel Dda University Health Board. She said that the Health Board had not reviewed Mr E's heart condition properly when he had attended an outpatient appointment at its Heart Valve Surveillance Clinic. She suggested that the Health Board should not have given Mr E clot-busting therapy, after his emergency admission to hospital, because there was no indication that he had had a recent stroke. She also said that the Health Board had failed to obtain Mr E's consent to that therapy. She suggested that the Health Board should not have given Mr E a beta blocker (a drug that can slow the heart rate by blocking the release of stress hormones) during that admission because that medication had done "more harm than good" due to his heart condition. She also said that the Health Board had not discussed its "Do Not Attempt Cardiopulmonary Resuscitation" ("DNACPR") decision with her.

The Ombudsman found that the Health Board had reviewed Mr E's heart condition appropriately. He did not uphold the outpatient management element of Ms D's complaint. He determined that it had been clinically appropriate for the Health Board to give Mr E clot-busting therapy and noted that that treatment decision had been taken in Mr E's best interests. He found that the beta blocker given to Mr E had not been clinically indicated because of Mr E's heart condition. He partly upheld the emergency treatment aspect of Ms D's complaint because the inappropriate use of a beta blocker had caused her a significant injustice, in the form of uncertainty and distress associated with the possibility that that medication might have hastened Mr E's death. He was satisfied that the Health Board had discussed its DNACPR decision with Ms D. He did not uphold the DNACPR decision part of Ms D's complaint.

The Ombudsman recommended that the Health Board should apologise to Ms D for the medication failing identified. He asked it to pay her £500 in recognition of the distress and uncertainty caused by that failing. He also recommended that it should take action to prevent a repetition of the medication failing. The Health Board agreed to implement these recommendations.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201901156 - Report issued in December 2020

Mrs A complained about the care given to her late mother, Mrs B, by Cwm Taf Morgannwg University Health Board ("the Health Board"). She said that the Health Board had failed to identify and diagnose a lump in Mrs B's chest promptly, to manage Mrs B's fluid build-up, to give Mrs B good nursing care, to provide adequate physiotherapy for Mrs B, to diagnose Mrs B's broken hip and to refer Mrs B to a rehabilitation hospital ("the Rehabilitation Hospital") without delay. Mrs A also complained about the Health Board's handling of her related complaint.

The Ombudsman found that the time taken for the Health Board to identify and diagnose Mrs B's chest lump was reasonable. He considered that the Health Board had managed Mrs B's fluid build-up appropriately. He determined that the Health Board had provided sufficient physiotherapy for Mrs B. He found that the Health Board had diagnosed Mrs B's hip fracture within a reasonable time frame. He considered that the Health Board had referred Mrs B to the Rehabilitation Hospital at appropriate times. He did not uphold these parts of Mrs A's complaint. The Ombudsman found that the nursing care that Mrs B had received ,in relation to her wound dressings, cannulation (the process of inserting a small tube (cannula) into a vein to deliver fluid, medication or blood products), positioning (moving around to prevent pressure ulcers), personal care and falls risk management, had been deficient. He considered that the inadequacy of Mrs B's cannulation had caused Mrs B, in terms of compromised treatment and distress, an injustice. He found that that care deficiency and those related to Mrs B's wound dressings, positioning and personal care had caused Mrs A an injustice in the form of distress about Mrs B's welfare. He considered that the falls risk management failings identified had caused Mrs A an injustice, in terms of ongoing uncertainty about whether a fall, which Mrs B had had in hospital, could have been avoided if they had not occurred. He upheld this element of Mrs A's complaint. He found that the Health Board's response to the fall-related part of Mrs A's complaint lacked rigour. He also noted that the Health Board had failed to give Mrs A a further response to some of her outstanding concerns after a meeting with staff members. He considered that the complaint handling failings identified had caused Mrs A an injustice in the form of prolonged distress. He upheld this aspect of Mrs A's complaint.

He recommended that the Health Board should apologise to Mrs A for the failings identified and pay her £500. He also asked it to develop an escalation procedure for cannula insertion and to provide written guidance about the investigation of falls for all relevant staff. The Health Board agreed to implement these recommendations.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201902014 - Report issued in December 2020

Mr A's complaint centred on his wife's management and the delay in the Health Board's Renal Dialysis Unit at Morriston Hospital ("the Hospital") seeking alternatives to the dressings and tapes to which his wife is allergic. As a result he said she was caused unnecessary pain and suffering. He was also dissatisfied with the Health Board's complaint handling and the robustness of its response.

The Ombudsman's investigation found evidence of steps being taken to investigate and manage Mrs A's allergic reaction as well as evidence of discussions and a plan of action being put in place to try to find the most pain free area for needle access. The Ombudsman concluded that broadly the Health Board's management and care regarding this aspect of Mrs A's treatment was reasonable. However, he did identify areas where her care could have been better. For example, there was no clear individualised care plan in place which would have strengthened the documented evidence regarding Mrs A's management, care and progress as well as helped to make communication between clinicians and Mr and Mrs A more effective and robust than it was. Additionally, basic clinical assessment tools relating to wound and pain management were not used. As a result of these clinical failings Mr and Mrs A were caused an injustice and it meant that the care provided to Mrs A was not as holistic or person-centred as it could have been. Given these failings, to this limited extent only the Ombudsman **upheld** this aspect of Mr A's complaint.

The Ombudsman felt that the Health Board's complaint handling had not been as robust as it could have been when it came to learning lessons from this complaint. The Health Board, having recognised additional shortcomings in how it dealt with Mr A's complaint, offered a small financial redress payment to Mr A in recognition of this which the Ombudsman welcomed. The injustice for Mr and Mrs A was that it added to their concerns about whether the Health Board had properly considered their complaint and therefore their sense of dissatisfaction. Given the shortcomings identified, the Ombudsman **upheld** this part of Mr A's complaint.

The Ombudsman recommended that the Health Board apologise to Mr and Mrs A for the failings identified in the report and at an appropriate clinical forum clinicians involved in Mrs A's care be reminded of the importance of accurate documentation of patients' allergies. In addition, personalised care plans, pain and wound assessments, if not already in place, should be implemented on the Unit, or nursing staff reminded of the need to complete these documentations if already in use, with the Health Board carrying out a follow-up audit regarding completion of these forms.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201902376 - Report issued in December 2020

Ms D complained about the care and treatment that her late sister, Mrs M, received from Gynaecology Services at Wrexham Maelor Hospital. Specifically, Ms D complained that:

a) Between May 2017 and January 2018, physicians incorrectly attributed Mrs M's gynaecological symptoms to multiple uterine fibroids (benign, non-cancerous growths on the wall of the uterus). This delayed investigations which eventually identified that she was suffering from uterine sarcoma (a rare form of cancer).
b) By the time surgical intervention was attempted, Mrs M's condition had become inoperable and the cancer had spread to other parts of her abdomen.
c) The manner in which a Consultant Obstetrician & Gynaecologist told Mrs M that any further treatment would be palliative in nature and that she should decide whether, in an emergency, she would wish to be resuscitated, was insensitive and unprofessional.

The Ombudsman upheld complaint 3 (on the grounds that Mrs M was not adequately supported by a family member or friend), but did not uphold complaints 1 and 2. With regard to complaint 1, the Ombudsman found that Mrs M was (initially) correctly diagnosed with uterine fibroids but that her sarcoma developed rapidly and aggressively. Whilst there was an avoidable delay of some weeks in arranging a scan (which in turn led to a delay in conducting further investigations), this interval would not have altered Mrs M's medical management. With regard to complaint 2, the Ombudsman found that Mrs M's surgery might have been attempted in January or February of 2018 (as opposed to late March), but there was no clinical evidence to suggest that this time interval would have led to any significant difference in outcome.

The Ombudsman recommended that the Health Board:

a) Provide Ms D with an apology for the identified failing surrounding the Consultant's discussion with Mrs M about resuscitation and the inoperable nature of her condition.
b) Makes a payment of £250 to Ms D in recognition of the distress that this failing gave rise to, and in recognition of how this event would have led to her feeling obliged to pursue a complaint about this matter.
c) Ensure that the report was shared with the physicians identified within it and that any learning points identified are reflected upon.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201903132 - Report issued in December 2020

Mrs N complained about the treatment her husband Mr N, received by a doctor within the Emergency Department ("ED") at Glan Clwyd Hospital. Mrs N said that the Doctor failed to assess her husband appropriately following a suspected transient ischemic attack ("TIA"). Mr N was instead treated for hypertension. Mr N suffered a stroke 2 days later.

The Ombudsman's investigation found that Mr N's presenting symptoms were suggestive of a TIA rather than hypertension, and the Doctor did not carry out a thorough enough assessment of Mr N to recognise the TIA, let alone to diagnose hypertension. This was in part due to a busy and overcrowded ED. The Ombudsman concluded that if Mr N had received aspirin immediately and had been referred to a TIA clinic, in line with national guidelines, his chances of avoiding a stroke 2 days later would have reduced by around 50%.

The Ombudsman upheld Mrs N's complaint.

The Ombudsman made wide ranging recommendations including that the Health Board apologise to Mr and Mrs N and consider Mr N's case at its Redress Panel. The recommendations also included clinical learning from Mrs N's complaint for the Doctor and staff within the Emergency Department. The Health Board also agreed to provide details of the actions it has taken to improve the safe management of patients in the ED at peak times.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201903530 - Report issued in December 2020

Ms A complained about the care provided to her daughter, Ms B, during labour and after the birth of her baby. In particular, Ms A complained that there was a delay in diagnosing Ms B's Acute Kidney Injury ("AKI"), that Ms B's Caesarean Section ("C-Section")should have been performed sooner and that despite Ms B wanting to breastfeed her baby, formula top-up feed was given and Ms B was not provided with a breast pump.

The investigation found that the care provided for Ms B's AKI was appropriate and in accordance with the relevant clinical standards. The complaint that there was a delay in diagnosis was therefore **not upheld**. The investigation found, however, that Ms B's C-Section could have been arranged earlier; this aspect of the complaint was **upheld**. It also found that although the nutritional needs of Ms B's baby had been met, poor recording keeping had created uncertainty about the reasons for formula feed being provided. This aspect of Ms A's complaint was therefore **upheld**.

The Ombudsman recommended that, within a month of the final report, Aneurin Bevan University Health Board("the Health Board") apologises in writing to Ms B for the failures identified and that, within 3 months, it provides evidence of reflection on the issues raised and reviews the breastfeeding support provided by staff across the Health Board to ensure a consistent approach is given.

A GP Surgery in the area of Hywel Dda University Health Board – Clinical treatment outside hospital
Case Number: 201903819 - Report issued in December 2020

Mrs A complained about the treatment provided to Mr B by a GP Practice in the local area and Hywel Dda University Health Board. In particular, she complained that the Practice failed to provide adequate monitoring or reviews of prescribed medication and did not provide appropriate mental health support following Mr B's discharge from psychiatric care in April 2017. Mrs A complained that the Health Board did not provide adequate assessment and treatment of Mr B's mental health during his admissions to the Psychiatric Intensive Care Unit and failed to arrange appropriate follow up care with the Community Mental Health Team.

The investigation found that there were failings in the Practice's record keeping and reviewing of controlled drugs and that it missed an opportunity to ensure that Mr B's level of risk was reviewed within an appropriate timeframe. Mrs A's complaints against the Practice were therefore **upheld**.

The investigation found that Mr B received appropriate assessment and treatment during his hospital admissions. This aspect of the complaint was therefore **not upheld**. The Ombudsman did however find shortcomings in the way the Health Board managed Mr B's referral from his GP in September 2017, which led to a considerable delay in assessment. An earlier assessment may not have changed the overall outcome of Mr B's case, but the uncertainty constituted an injustice to his family. This aspect of the complaint was **upheld** to that extent.

The Ombudsman recommended that both the Practice and the Health Board apologise to Mrs A for the failings identified within 1 month, and that within 3 months the Practice reviews its procedures for prescribing controlled drugs. The Ombudsman also recommended that both the Health Board and the Practice review the way in which GP mental health referrals are managed and that both organisations should reflect on the failings identified in the investigation.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201903824 - Report issued in December 2020

Mrs A complained about the treatment provided to Mr B by a GP Practice in the local area and Hywel Dda University Health Board. In particular, she complained that the Practice failed to provide adequate monitoring or reviews of prescribed medication and did not provide appropriate mental health support following Mr B's discharge from psychiatric care in April 2017. Mrs A complained that the Health Board did not provide adequate assessment and treatment of Mr B's mental health during his admissions to the Psychiatric Intensive Care Unit and failed to arrange appropriate follow up care with the Community Mental Health Team.

The investigation found that there were failings in the Practice's record keeping and reviewing of controlled drugs and that it missed an opportunity to ensure that Mr B's level of risk was reviewed within an appropriate timeframe. Mrs A's complaints against the Practice were therefore **upheld**.

The investigation found that Mr B received appropriate assessment and treatment during his hospital admissions. This aspect of the complaint was therefore **not upheld**. The Ombudsman did however find shortcomings in the way the Health Board managed Mr B's referral from his GP in September 2017, which led to a considerable delay in assessment. An earlier assessment may not have changed the overall outcome of Mr B's case, but the uncertainty constituted an injustice to his family. This aspect of the complaint was **upheld** to that extent.

The Ombudsman recommended that both the Practice and the Health Board apologise to Mrs A for the failings identified within 1 month, and that within 3 months the Practice reviews its procedures for prescribing controlled drugs. The Ombudsman also recommended that both the Health Board and the Practice review the way in which GP mental health referrals are managed and that both organisations should reflect on the failings identified in the investigation.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201904637 - Report issued in December 2020

Ms D complained about the care and treatment she received at Wrexham Maelor Hospital ("the Hospital") when, following a mental health crisis, she took a non-accidental overdose of paracetamol and diazepam. Ms D complained that:

1. Emergency Department (ED) clinicians failed to assess and treat her in accordance with relevant clinical guidance.
2. She was discharged within a matter of hours without her psychological condition being adequately assessed and was allowed to drive home despite this posing a significant risk to her safety.

Ms D also complained about the circumstances surrounding her scheduled admission to the Hospital's

Adult Mental Health Unit ("the Unit") some days later. Specifically, Ms D complained that:

1) Following her arrival at the Unit, she became involved in a violent altercation with a female inpatient (Ms X) in the reception area. Clinicians failed to respond sufficiently quickly to prevent this.
2) Clinicians decided, on safety grounds, that she could not be admitted to the same ward as Ms X. However, the proposed alternative ward was not appropriate for her care needs, and she was obliged to discharge herself.

The Ombudsman upheld complaint 2 to the extent that, whilst there was no evidence to suggest that Ms D was not fit to drive home (and, therefore, no basis for her to be detained/prevented from doing so), a fresh, comprehensive psychosocial risk assessment should have been completed. Whilst observations concerning risk were recorded in Part C of the (Mental Health) Measure documentation, this was brief and did not capture the many dynamic (changeable and context-related) risk factors that might have been considered. The Ombudsman considered this an injustice to Ms D in view of her volatility and unpredictability.

The Ombudsman did not uphold complaints 1, 3 and 4. He found that Ms D was assessed and treated at the ED in accordance with established procedure and that clinicians could not have anticipated or prevented the altercation between Ms D and Ms X. The Ombudsman agreed that, on safety grounds, Ms D could not have been admitted to the same ward as Ms X. However, he was satisfied that Ms D was offered appropriate alternatives and was not denied admission to the Unit.

The Ombudsman recommended that Ms D receive a fulsome apology for the identified risk-assessment failing. He also recommended that the Health Board reminds front-line mental health clinicians of the requirement, under NICE Guidance, to document dynamic risk on each occasion of self-harm (even when previous good quality assessments are available) and to update care plans accordingly.

Cardiff and Vale University Health Board & Velindre University NHS Trust - Clinical treatment in hospital
Case Number: 201905223 & 201905224 - Report issued in December 2020

On 26 April 2017 Mr X was diagnosed with advanced, inoperable colon cancer and he was told that any treatment would only be palliative. Mrs X complained about the treatment her late husband, Mr X received from the Cardiff and Vale University Health Board (the Health Board) and Velindre University NHS Trust (the Trust) at University Hospital Wales(the First Hospital), University Hospital Llandough (the Second Hospital)and Velindre Cancer Centre (the Centre). Mrs X complained that in February 2017 urgent cancer investigations should have been arranged after Mr X's admission, a biopsy sample should have been taken before5 May and it was not reasonable that the biopsy results were not available before an appointment on 16 May at the Centre. Mrs X complained about Mr X's treatment and discharge at the First Hospital between 16 May and23 May and in view of his terminal diagnosis, visiting times should have been flexible between 14 and 21 January 2018. Mrs X complained about Mr X's treatment and discharge at the Second Hospital between 19 and26 May and the catheter management between 27 and 30 May. Mrs X complained about Mr X's referral to palliative services and that the family were not given appropriate information. Mrs X also complained that communications between the Health Board and Trust about Mr X's treatments were not appropriate.

On 12 July Mr X sadly, died. The Ombudsman found that Mr X was discharged for urgent investigations in February 2017, it was reasonable that a biopsy was taken on 5 May 2017, his treatments and discharges between 16 and23 May 2017, and 19 and 26 May 2018 were reasonable as was the catheter management between 27 and 30 May. He found that Mr X was appropriately referred to palliative services and Mrs X was spoken to about her concerns. He also found that while Mr X's care was coordinated, there was a lack of communication between the MDT, surgical and oncology teams. Appointments were not coordinated to the availability of results, although it did not affect the clinical outcome. These aspects of

the complaint were not upheld. The Ombudsman found that the MDT had not arranged the 16 May 2017appointment to correspond with the biopsy results and there was no need to for Mr X to have attended this appointment. He found that between14 and 21 January 2018 Mrs X should have been allowed flexible visiting. He also found that between 27 and 30 May Mr X's catheter management was reasonable, however, he found that on 27 May Mr X was discharged without a drug chart that led to delay in his care. These aspects of the complaint were upheld.

The Trust agreed to implement the Ombudsman's recommendations within 1 month and apologise to Mrs X that Mr X attended an unnecessary appointment on 16 May 2017. The Health Board agreed to implement the Ombudsman's recommendations within 1 month and apologise to Mrs X that visiting between 14 and 28 January 2018 was inflexible and remind staff to adopt a more flexible approach for other patients' families in similar situations within. It also agreed within 3 months to remind staff that when patients are discharged their drug chart, medication and equipment accompanies them. The Trust and Health Board agreed that within6 months teams within the Colorectal MDT would review coordination between diagnosis, availability of results and appointments to ensure unnecessary appointments are avoided.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201905314 - Report issued in December 2020
Mr A complained about the care and treatment that was afforded to his late father (Mr B). Mr A complained about the dose of midazolam administered, that Mr B's death was accelerated by the end of life medication administered, that the failure to follow guidelines on palliative care were not reported on appropriately and in a timely manner and that the family were not provided with sufficient and clear information regarding the end of life medication and palliative care Mr B was given.

The investigation found that the dose of midazolam was within an acceptable range. There was no evidence that Mr B experienced opiate toxicity during the administration of the end of life medication and the prescription did not cause an acceleration in his death. The investigation found that the Health Board failed to mention a medication error to the Coroner, the family and to log it as a DATIX incident report in a timely manner. This raised Mr A's suspicions that attempts were made to "cover up" a prescribing error, which amounted to an injustice. In addition, the investigation found that a more detailed discussion with the family would have provided them with a better understanding of the term "TLC" and what that entailed both practically and emotionally for them and Mr B. Consequently, this would have prepared them for the end of his life. The latter two aspects of the complaint were upheld.

The Health Board agreed to apologise to Mr A for the failures identified and to disseminate a circular to all staff likely to hold discussions with family members around end of life care which would identify the issues that should be raised and discussed to ensure families are appropriately informed and prepared when a decision is taken to commence end of life care. It agreed that the circular would emphasise that discussions should always be documented within the patients clinical records.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905386 - Report issued in December 2020
Mrs A complained that Betsi Cadwaladr University Health Board had mismanaged her total right hip replacement operation ("operation"). She also reported that the Health Board had not investigated and treated the sensation and functionality problems, which she had experienced in her right leg since that operation, properly. Mrs A also complained about the Health Board's handling of her complaint. She said that it had not given her a second clinical opinion about her care, despite indicating that it would do so. She also reported that it had taken too long to respond to her complaint.

The Ombudsman found that the Health Board had managed Mrs A's operation appropriately. He did not uphold this aspect of Mrs A's complaint. He found that the Health Board's investigation of Mrs A's post-operative symptoms had been deficient because it had not shown that it had assessed her leg length and

pain level after her operation. He considered that those deficiencies had caused Mrs A an injustice by not reducing her uncertainty and anxiety about what might have led to those symptoms. He found that the Health Board should have prescribed a foot drop splint (this holds the foot in a normal position) for Mrs A and that it should have given her more physiotherapy. He considered that those shortcomings had caused Mrs A an injustice by potentially delaying an improvement in her mobility. He partly upheld this element of Mrs A's complaint. He found that the Health Board had failed to give Mrs A a second opinion and to promptly tell her that it was unable to do this. He considered that those failings had caused Mrs A an injustice in the form of an unfulfilled expectation and prolonged uncertainty. He upheld this part of Mrs A's complaint. He found that the Health Board had taken too long to respond to Mrs A's complaint. He considered that the delay associated with that response had caused Mrs A, in terms of prolonged uncertainty, an injustice. He upheld this aspect of Mrs A's complaint.

The Ombudsman recommended that the Health Board should apologise to Mrs A for the failings identified and that it should pay her £500. He also asked it to prepare a memorandum, which highlights the clinical issues raised by Mrs A's complaint and identifies key learning points, for all relevant orthopaedic staff. The Health Board agreed to implement these recommendations.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905743 - Report issued in December 2020

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") and a Health Board managed GP Practice ("the Practice") failed in their care and treatment of her mother, Mrs Y, between 29 September and 21 November 2018. In particular, that the Health Board inappropriately discharged Mrs Y from a community hospital on 29 September following a fall in which she injured her head; that it failed to carry out a CT scan following an attendance at another hospital on 3 October, and that an out of hours GP ("the OOH GP") failed to review/assess Mrs Y on 18 November when she attended another community hospital. Mrs X complained that the Practice failed to obtain further clinical opinions following Mrs Y's attendances on 8 and 19 November.

The Ombudsman found that Mrs Y was inappropriately discharged on 29 September and she should have been referred to an Emergency Department for further investigations, including a CT head scan. He upheld this complaint. The Health Board was unable to locate Mrs Y's records for the 3 October attendance at hospital. The loss of these records amounted to maladministration as the Ombudsman was unable to reach a finding on this complaint. This was a significant injustice, and so the complaint was upheld. The Ombudsman found that the record keeping for the 18 November attendance was below expected standards, he was therefore unable to determine whether Mrs Y was appropriately reviewed/assessed by the OOH GP. He upheld this complaint as the poor record keeping did not demonstrate that a clinically appropriate assessment took place. Finally, the Ombudsman found that Mrs Y's management by the Practice on 8 November was adequate. However, the record keeping for the 19 November attendance was not of an adequate standard to conclude whether there was a failure to obtain a further clinical opinion and so he upheld the complaint to this extent. The Health Board agreed to the Ombudsman's recommendations which included an apology, training and reflection.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202000164 - Report issued in December 2020

Miss O complained that the Health Board failed to appropriately investigate or treat her mother, Mrs L's symptoms of diarrhoea and vomiting at St. Woolos Hospital between 26 November and 30 December 2018.

The investigation found that the Health Board should not have transferred Mrs L from the Royal Gwent Hospital to St Woolos Hospital on 26 November because she was not medically fit for rehabilitation. It found that because of Mrs L's persistent diarrhoea and vomiting, she could not be adequately managed at St.Woolos Hospital and that she should have been transferred back to the Royal Gwent Hospital for more intensive medical review. The failure to provide care in an appropriate environment caused avoidable

distress to Mrs L and Miss O which amounted to an injustice. The Ombudsman therefore **Upheld** the complaint.

The Ombudsman recommended that the Health Board apologise to Miss O for the failings identified and make a financial redress payment of £250 in respect of the associated distress. The Ombudsman also recommended that the Health Board provide a written update within 3 months on its ongoing work to ensure appropriate transfers between acute hospitals and community hospitals.

Not Upheld

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201907117 - Report issued in October 2020

Mr A complained that there was a delay by Cardiff and Vale University Health Board ("the Health Board") in diagnosing his sister Ms B's, lymphoma (a **cancer that affects the lymphatic system**; a network of vessels and glands that runs throughout the body) between January and June 2019.

The investigation found that Ms B underwent appropriate investigations and that she was provided appropriate treatment. It also found that Ms B was reviewed by appropriate specialists during her admissions and that a multi-disciplinary approach was taken in respect of her care and treatment, with detailed thought going into her management. Ms B's clinical picture was rare and one that might only typically be encountered once or twice in a respiratory clinician's career. As such, Mr A's complaint was not upheld.

The investigation noted that the Health Board acknowledged that clinicians did not communicate clearly with Ms B and her family about her care and treatment. Had it done so, it is possible that Ms B and her family would have had a better understanding of the treatment, investigations, possible diagnoses being considered and excluded and the prognosis. It would also have afforded Ms B and her family the opportunity to seek clarification and ask any questions about her ongoing care and treatment. It was suggested that the Health Board shared the Ombudsman's report with all Respiratory Consultants to demonstrate the importance of good communication with patients and their families, and to aid their learning and development. The Health Board agreed to do so.

A GP Practice in the area of Cardiff and Vale University Health Board - Clinical treatment outside hospital
Case Number: 201901919 - Report issued in October 2020

Miss A complained on behalf of her mother Mrs B, that the GP Practice failed to provide appropriate and timely treatment of an infected/ischaemic (inadequate blood supply to a part of the body) toe. Particularly, Miss A said that the GP Practice failed to act on a request for a home visit, and that Mrs B should have been admitted to hospital sooner. Sadly, Mrs B's foot infection deteriorated such that she underwent a below the knee leg amputation. Miss A believed that the loss of Mrs B's limb was avoidable.

The Ombudsman found that the records of the GP consultations provided evidence of appropriate and timely assessment and treatment of Mrs B's infected toe that took account of her history of peripheral arterial disease (narrowing of the blood vessels to parts of the body). Although Mrs B's condition deteriorated, there was no evidence that she had features of acute limb ischaemia (a rapid decrease in the blood flow to the lower limbs), requiring an emergency vascular assessment in hospital. The Ombudsman could not say with certainty whether the request for a home visit was made, but he was satisfied that the additional 3 days before Mrs B was seen by a GP would not have had any impact on her clinical condition or the outcome.

The Ombudsman did not uphold the complaint.

Swansea Bay University Health Board - Patient list issues
Case Number: 201904201 - Report issued in October 2020

Mrs X complained about her treatment at Morriston Hospital. She questioned whether 13 November 2018 was the correct date that she was placed on the urgent waiting list for revision knee surgery and whether her treatment should have been considered for outsourcing at another hospital.

The Ombudsman's investigation found that Mrs X was appropriately placed on the waiting list for surgery on 13 November 2018. He also found that Mrs X was not suitable to be provided with treatment by an outsourced provider. The Ombudsman did not uphold Mrs X's complaints.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201904045 - Report issued in November 2020
Mrs A complained about the anaesthetic care and treatment she received from Betsi Cadwaladr University Health Board during a Caesarean Section on 2 January 2015. In particular, she complained that a nerve in her right arm was damaged by the incorrect insertion of a cannula (a thin tube inserted into the vein to administer medication or drain fluid), resulting in a diagnosis of subacromial bursitis (inflammation of the upper shoulder joint).

The investigation found no evidence that Mrs A's care and treatment had been of an inappropriate standard and no evidence that the insertion of a cannula was likely to have caused subacromial bursitis. The complaint was therefore **not upheld**.

Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 201905005 - Report issued in November 2020

Mrs X complained about the care provided to her son Mr Y, by Swansea Bay University Health Board's Mental Health Services between April 2017 and March 2018. The investigation considered whether the level of mental health input, monitoring and assessment Mr Y received was appropriate and in line with relevant guidance/legislation/measures. It also considered the management of Mr Y's medication given his history of non-compliance (which appeared to be symptomatic of his mental ill-health). Mr Y sadly committed suicide in March 2018.

The Ombudsman found that, although Mr Y had in the past, thoughts of suicide (in 2007 and 2014), there was no evidence before his death that he was thinking of suicide or that he had become so ill that formal admission under the Mental Health Act 1983 was indicated before her tragically took his own life. Whilst there were some aspects of Mr Y's care that could have been better (failure to arrange an appointment with a psychiatrist within 2 weeks of hospital discharge in accordance with guidance; no follow up appointment to review a change of medication), the evidence overall did not suggest that there were any failings of care in the monitoring, input and assessment of Mr Y's mental health, or in the management of his medication, such that the tragic outcome could be attributable to the actions of the Health Board. The complaint was not upheld.

Betsi Cadwaladr University Health Board - Non-medical services
Case Number: 201903750 - Report issued in November 2020
Mrs X complained that a response she received from a consultancy company on behalf of Betsi Cadwaladr University Health Board, in response to questions about an investigation report that she had received, did not address her concerns and was not evidence based.

Mrs X said that the consultancy company did not have access to the information that was available to it during its initial investigation. The Ombudsman's investigation found that, whilst the consultancy company did not have access to the information it considered during its initial investigation, it had access to sufficient evidence to address Mrs X's concerns. The Ombudsman was satisfied that the consultancy company appropriately identified and addressed Mrs X's concerns.

Mrs X also raised concerns about findings made by the consultancy company in relation to an allegation of

abuse. Mrs X believed that the Health Board had attempted to deceive her in relation to this matter. The Ombudsman's investigation found that the consultancy company's conclusions were reasonable and evidence based and found no evidence that the Health Board had attempted to mislead her in relation to this matter.

The complaint was not upheld.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201904926 - Report issued in November 2020

Ms G complained that Cwm Taf Morgannwg University Health Board ("the Health Board")failed to appropriately monitor her late mother, Mrs H's liver disease. She was concerned that if closer monitoring had taken place, her mother's deterioration and death may have been avoided. Ms G was also concerned about the standard of communication between the health professionals and her mother about her condition between June 2018 and July 2019.

The investigation found that there was maladministration and service failure in this case as a follow-up appointment which should have been arranged for Mrs H did not take place. As a result, she also did not receive repeat scans and blood tests which would have been arranged at the follow-up appointment. However, sadly, even if these had taken place as they should, Mrs H's rapid and unexpected deterioration and death would not have been prevented. Given that the maladministration and service failure in this case did not therefore result in an injustice to Mrs H, the Ombudsman **did not uphold** the complaint. The Ombudsman was pleased to note, however, that the Health Board had already taken steps to amend its booking system to ensure that patients are not overlooked for follow-up appointments and that it had reported that these changes appeared to be effective.

The Ombudsman also **did not uphold** the complaint about communication. Although this would have been improved if the follow-up appointment had taken place, key information about the likely diagnosis and the need to abstain from alcohol had been provided at previous appointments and repeated in correspondence.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 202000059 - Report issued in November 2020

Mr B complained about the care and treatment he received from Cardiff and Vale University Health Board ("the Health Board"). Specifically, Mr B complained that the Health Board failed to provide appropriate or timely treatment which resulted in his condition deteriorating and failed to provide appropriate care and treatment while he was an inpatient in the University Hospital of Wales ("the Hospital"). Finally, Mr B complained that the Health Board failed to appropriately discharge him from the Hospital and provide him with appropriate follow-up care and support.

The Ombudsman did not uphold Mr B's complaints. The investigation found that Mr B underwent surgery in a timely manner and that the time taken to undergo further tests and investigations did not have any clinical impact on Mr B's condition. The Ombudsman's investigation also found that Mr B received appropriate care and treatment while he was an inpatient in the Hospital. Mr B was appropriately reviewed by the specialist stroke team throughout his inpatient stay and was prescribed appropriate medication.

Finally, the Ombudsman found that Mr B's discharges from the Hospital, on both 23 July 2019 and 30 August 2019, were appropriate. Mr B received appropriate follow-up care from the Health Board. As a result, the Ombudsman did not uphold Mr B's complaints. However, it was noted that the Health Board failed to refer Mr B to the Neurology Department for an outpatient review. Although the Ombudsman found that this did not have any clinical impact on Mr B, he suggested that the Health Board considered his comments and reviewed its referral system for patients discharged from the Hospital requiring neurology review.

Cwm Taf Morgannwg University Health Board & Velindre University NHS Trust - Clinical treatment in hospital
Case Number: 201904410 & 201905415 - Report issued in November 2020

Mr X complained whether his late wife Mrs X, should have been given radiotherapy (the use of radiation to kill cancer cells) between 1 March 2018 and 16 May.

In September 2017 Mrs X was diagnosed with squamous cell cancer of the lung and referred to the Trust. On 11 October at Velindre Cancer Centre ("the Centre") Mr and Mrs X were told the cancer was likely incurable. Mrs X consented to 4 cycles of chemotherapy and dependent on how she responded, she would have high dose radiotherapy. Mrs X was administered chemotherapy between 24 November 2017 and 29 January 2018. On 18 April Mrs X was admitted to the Prince Philip Hospital ("the Hospital) with a shortness of breath. She was to be considered for radiotherapy, but as she was admitted with a severe infection it could not be arranged. An appointment for Mrs X to attend the Centre on 4 May for palliative radiotherapy was cancelled as she Was unwell and it was re-arranged for 8 May when she attended planning for palliative radiotherapy. On 10 May Mrs X attended the Centre for radiotherapy but she was too distressed for treatment and returned to the Hospital. On 17 May it was agreed that should Mrs X remain stable enough for 3 days she would be transferred for radiotherapy. She remained too unwell for radiotherapy and sadly died on 21 May.

The Ombudsman found that Mrs X's treatment was appropriate and there were no missed opportunities to have received radiotherapy. The complaint was not upheld.

Velindre University NHS Trust (Former University Hospitals Bristol NHS Foundation Trust) - Clinical treatment in hospital
Case Number: 201906504 - Report issued in November 2020

Ms C complained that the former University Hospitals Bristol NHS Foundation Trust mismanaged the termination of her pregnancy. She said that the Trust had not calculated the gestational age (the estimated age of the unborn baby) of her late son, D, correctly. She contended that the Trust should not have performed her termination until it had obtained the results of her amniocentesis (a diagnostic test to check if a baby has a genetic or chromosomal condition). She stated that the Trust had not enabled her to give valid consent to her termination. She said that the Trust had not ensured that the Second Doctor had examined and/or spoken to her before she signed the "certificate of opinion" ("the Certificate") required by termination law. She said that the Trust had not given her any choice about the method that would be used for her termination. She reported that the Trust had not used the correct type and amount of medication when performing that procedure.

The Public Services Ombudsman for Wales and the Parliamentary and Health Service Ombudsman investigated Ms C's complaint on a joint basis. This was because the Trust was providing services on behalf of a Welsh health body. The Ombudsmen found that the Trust had calculated D's gestational age correctly, that it had not been necessary for it to wait for the results of Ms C's amniocentesis before performing her termination and that it had enabled Ms C to give valid consent to that procedure. They determined that it had not been necessary for the Trust to have ensured that the Second Doctor had examined and/or spoken to Ms C before signing the Certificate. They did not consider that it was reasonable to criticise the Trust for not giving Ms C a choice about the method used for her termination. They found that the medication used by the Trust for that procedure was appropriate. They did not uphold any part of Ms C's complaint against the Trust.

A GP Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201904180 - Report issued in November 2020

Mrs A had recently moved to the GP Practice's ("the Centre") area. She complained about the first 2 appointments she attended to both register as a patient with the Centre, and to seek advice from a GP about her baby son (X)'s reflux symptoms. Mrs A told the GP that X had been prescribed indigestion

drugs by her former GP, which she said had not worked, and that specialist formula milk had been suggested. She also asked about scheduling X's 6-8 week health appointment then due. She complained that the GP did not examine X, she was given no date for the 6-8 week appointment and when she changed to a different GP Centre, a couple of weeks later, they had referred X to a specialist who diagnosed him with a chest condition (pectus excavatum). She considered that the Centre ought to have diagnosed this sooner.

During the investigation the Ombudsman sought advice from a Professional Adviser. He noted that when Mrs A first visited the Centre she was registering as a new patient, and that the GP did not have any of X's clinical records available to him. They had not yet been transferred from his former GP. He said there was no necessity for the GP to examine X given what was discussed, and that it would not have been wise for the GP to prescribe medication without the benefit of those records. Until they arrived, it was not possible to arrange the 6-8 week appointment either at which X would undergo a full examination, as happened. Nevertheless, the GP had prescribed a small amount of the specialist milk formula, which was also available over the counter without prescription. The Ombudsman concluded that this was done to assist Mrs A. The Adviser noted that pectus excavatum usually showed no symptoms and it is often a "by chance" diagnosis, as it was at X's health check a month later. The few weeks delay made no difference to the outcome. Nothing would have changed even had the GP at the Centre examined X and diagnosed the condition earlier. The Ombudsman **did not uphold** the complaint.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201904140 - Report issued in December 2020

Mrs G complained about care commissioned by Swansea Bay University Health Board ("the Health Board)") and provided by an NHS Trust in England. She complained about the decision in 2017 not to offer further surgery following the removal of her gastric band and in particular, the failure to advise her of the decision earlier. Mrs G also complained about issues concerning record-keeping.

The Ombudsman concluded that the decision not to offer revisional surgery in the form of a gastric bypass was reasonable, in view of Mrs G's specific circumstances. However, it was less clear whether the Trust had considered the alternative, but perhaps less effective, procedure of a gastric sleeve. Although he did not uphold the complaint the Ombudsman suggested that the Health Board obtain a second opinion to explore opportunities for revisional surgery for Mrs G, which the Health Board agreed to do. The Ombudsman found that the Trust's record-keeping was of an acceptable standard for the time. Nevertheless, the Health Board had already accepted there were some failings in its own record-keeping, and the failure to inform Mrs G of the outcome of a meeting, and offered a small redress payment in recognition of this.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201904192 - Report issued in December 2020

Mr A complained that the Health Board failed to investigate and diagnose the cause of his urinary symptoms in a timely fashion, and that this delay resulted in a reoccurrence of his prostate cancer.

The investigation found that Mr A's symptoms were appropriately investigated according to what was known at the time, and that there were no significant delays. It also found that Mr A's cancer diagnosis related to 2 new cancers, and not a re-occurrence of his previous prostate cancer. The complaint was therefore **not upheld**.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201905426 - Report issued in December 2020

Mr X complained that the increased risk of complication to African-Americans from cataract surgery was not explained to him during the consenting process for cataract surgery to his right eye on 5 February 2016 (a risk which he said was only highlighted to him in a meeting with a Consultant Ophthalmologist in January 2019). As a result, Mr X said he was not given clinically appropriate and relevant information to

make an informed decision about undergoing this surgery. He also complained that the Health Board failed to appropriately monitor the prolonged use of Pred Forte ("PF" - a steroid anti-inflammatory drug used in adults for the treatment of eye inflammation) after his surgery and the impact of the prolonged use on his eye health.

The Ombudsman found that an article published in 2019 which highlighted an increased risk of uveitis (an inflammation of the middle layer of the eye which can cause eye pain and changes to vision) to African-American patients following cataract surgery was not published when Mr X consented to undergo the surgery. The risk brought to Mr X's attention following the meeting in January 2019 was not known about at the time of his surgery and so could not have formed part of the information given to him during the consenting process. There was no omission in the consenting process. This complaint was **not upheld**.

The Ombudsman found the use of PF was justified in Mr X's case and there was no documented impact of the prolonged use on his right eye. He found that there was a communication shortcoming and that clinicians should have discussed with Mr X the length of time he should use PF and the regime for reducing it. This was a service failure. However, based on the clinical advice, there was no adverse consequence to Mr X as a result of this shortcoming. This complaint was **not upheld**. However, the Ombudsman invited the Health Board to refer the report to the Ophthalmology Department to discuss this report at a Consultant Meeting and consider how it can improve communication with patients about the use of PF.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201905534 - Report issued in December 2020

Mr T complained about the care and treatment his late wife, Mrs T, received from the Health Board from September 2018 until 3 January 2019 in relation to her diagnosis of pancreatic cancer. In particular, Mr T was unhappy at the Health Board's failure to carry out a transvaginal ultrasound scan to check for ovarian cancer, failure to follow-up an elevated CA125 level, failure to recognise the symptoms of ovarian and pancreatic cancer, and the delay in diagnosing Mrs T's pancreatic cancer and providing a treatment and care pathway.

The Ombudsman's investigation found that there was no requirement to carry out a transvaginal ultrasound scan based on Mrs T's presenting symptoms, Mrs T's CA125 levels were appropriately followed up, Mrs T did not have ovarian cancer and her pancreatic cancer was diagnosed following timely and appropriate tests. He did not uphold the complaint.

However, the Ombudsman did find that the standard of communication with Mr and Mrs T in relation to Mrs T's cancer diagnosis was poor and he could not be certain from Mrs T's medical records when exactly the diagnosis was discussed with them both. Whilst this was not part of the scope of the complaint, the Ombudsman invited the Health Board to apologise to Mr T and to share his report with those involved in Mrs T's care to facilitate learning and to remind them of the essential need for detailed and accurate record keeping. The Health Board agreed to this invitation.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202000474 - Report issued in December 2020

Mr C complained that a spinal anaesthetic injection (a procedure designed to cause loss of sensation) carried out before a knee operation at Wrexham Maelor Hospital ("the Hospital") on 9 October 2019 did not meet accepted standards. In particular, he was concerned that the procedure had caused him to develop urinary incontinence (the unintentional passing of urine). He also complained that clinicians at the Hospital were aware that he had developed urinary incontinence, or was at risk of developing it but discharged him on 14 October without informing him or providing appropriate support.

The investigation found that the spinal anaesthetic injection did not cause Mr C's urinary incontinence. There was no evidence that the procedure was carried out inappropriately or caused injury to Mr C's

spinal cord. In any event, urinary incontinence was not a recognised long-term complication of spinal anaesthetic procedures. This element of the complaint was therefore **not upheld**.

The investigation found that there was no evidence that clinicians at the Hospital were aware that Mr C had developed urinary incontinence or suspected it as a possibility. Records indicated that Mr C had urinated normally on 14 October before his discharge and there were no indications that he would experience the first episode of urinary incontinence later that day. This element of the complaint was therefore **not upheld**.

Early Resolution or Voluntary Settlement

Betsi Cadwaladr University Health Board - Other
Case Number: 202002747 - Report issued in October 2020
Mr X complained that Betsi Cadwaladr University Health Board ("the Health Board") had not rearranged a Zoom meeting between it and Mr X to discuss outstanding issues.

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

- On Thursday 26 November 2020 at 10:45am, the Health Board will chair a meeting with Mr X and relevant staff.

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

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202001765 - Report issued in October 2020
Mr A complained regarding the care and treatment provided to his late father after he was admitted to one hospital and later transferred to another within Aneurin Bevan University Health Board's ("the Health Board's") area. He complained that the Health Board's response letter to him at stage two of its complaints procedure lacked detail and contained inaccuracies. The Health Board had stated in a further letter to him that it would re-open his case at a later date.

The Ombudsman found that the response letter was not as complete a response as would be expected to the issues raised by the complainant. He was also concerned that the offer to re-open the complaint at a later stage did not appear to provide a definitive timescale for the response letter to be completed. He also considered that the offer of a local resolution meeting may provide further closure for the complainant. He therefore, contacted the Health Board.

It agreed to:

a) Write a further letter to Mr A providing a date when it will provide him with a further letter of response regarding the issues he raised and any outstanding issues it did not address in its original response letter.
b) The letter will also offer Mr A the opportunity to meet with relevant staff should he wish to in order to seek to provide a resolution to his complaint.

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

The Ombudsman believes that this is an appropriate settlement and the complaint file will closed.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202002360 - Report issued in October 2020
Mrs X's complaint concerned the care that was afforded to her late son, by the Health Board's Mental Health Team. She specifically complained that the Health Board had failed to fully respond to her complaint concerning the period of his care that took place between October 2016 and March 2018.

The Ombudsman took into account that the Health Board had previously provided a written response to Mrs X's complaint on 12th May 2020. However, having carefully considered the points which she raised in her complaint letter to him, he concluded that it would be helpful for her to receive a further response from the Health Board.

The Health Board agreed to provide Mrs X with a written response to the points raised in her letter to the Ombudsman dated 29 June 2020 under the heading 'October 2016 to March 2018'. The Health Board agreed to provide the response within 30 working days from the date the Ombudsman issues his decision.

Betsi Cadwaladr University Health Board - Continuing care
Case Number: 202001572 - Report issued in November 2020
Mr X complained about the Health Board's failure to properly assess his wife, Mrs X's, claim for NHS Funded Continuing Care ("NHSFCC"), particularly following criticism of its assessment by an Independent Review Panel.

The Ombudsman contacted the Health Board, which agreed to the reassess Mrs X's needs, ensuring that it fully engaged with Mr X throughout the process, and to consider the claim for the entire period during which she had been resident in the care home under the national framework for retrospective claims. The Ombudsman considered this to represent an appropriate settlement.

Hywel Dda University Health Board – Other
Case Number: 202001868 - Report issued in November 2020
Mr X complained about the manner in which the Health Board had dealt with his complaint to it against his GP Practice. A meeting had been arranged, but this was not able to take place due to the coronavirus restrictions and there was disagreement about whether the meeting could be productively held virtually. The complaint had therefore not progressed.

The Health Board agreed that a meeting could take place virtually between the GP and the complainant, so that the complaint could be properly discussed and matters progressed.

Swansea Bay University Health Board - Continuing care
Case Number: 202003235 - Report issued in November 2020
Ms A complained about Swansea Bay University Health Board's ("the Health Board") failure to follow correct procedures in relation to a claim for retrospective NHS continuing healthcare submitted to it in relation to her mother. Ms A said that the Health Board failed to undertake an assessment of her mother's primary health needs for the period concerned, provided inadequate communication and errors in its financial calculations.

The Ombudsman found that the Health Board had overlooked the fundamental issue of whether Ms A's mother actually qualified for NHS continuing healthcare for the period concerned as it had not undertaken an assessment of Ms A's mother to determine this issue one way or another. The fact that Ms A's mother had undergone an assessment for her social care needs would not preclude her from undergoing an assessment for her primary healthcare needs. Only once eligibility had been determined would financial calculations become a material consideration for the Health Board.

The Ombudsman contacted the Trust and it agreed to - within 3 months:

- Undertake a full assessment, in accordance with the National Framework, to determine Ms A's mother's eligibility for NHS funded continuing healthcare, for the period 6 January 2019 to 12 September 2019.

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

complaint.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202002759 - Report issued in November 2020
Ms X complained about the information set out in a response letter she received from a doctor about concerns she had raised. She said that the information was contradictory and inaccurate. Ms X had been attempting to contact the writer to discuss the outcome but with no success.

The Health Board apologised to Ms X for her difficulties in contacting the writer and offered to meet to discuss the outcome of the complaint. It also agreed to write to her within two weeks of the meeting with a summary of it.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 202003135 - Report issued in November 2020
Mr & Mrs X complained about the care and treatment provided by Cwm Taf Morgannwg University Health Board ("the Health Board") to their late mother / mother-in-law whilst she was in hospital. They specifically commented on a fall she had which they believe attributed to the deterioration in her health. Mr & Mrs X further complained that the Health Board's formal complaint response had not fully answered their concerns and that it raised further queries.

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

By 17 December 2020:

- The Health Board will issue Mr & Mrs X with a further written response answering their additional outstanding questions.

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

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 202002487 - Report issued in November 2020
Mr X complained about the response he had received from the Health Board following a previous investigation by the Ombudsman about the care and treatment received by his late wife. He was unhappy with the content of the letter and the explanations given.

The Ombudsman declined to investigate and considered that the Health Board had provided a detailed response which addressed the issues that were previously raised by Mr X. Consideration has been given to clinical records and that staff involved in Mr X's late wife's care had been consulted where appropriate. However, it seemed that the Health Board were able to respond more fully and provide the documents sought. The response had also raised further issues and questions for Mr X, some of which the Health Board had not had an opportunity to consider and respond to.

The Health Board agreed to within 30 working days provide Mr X with a detailed written response to the matters raised in his letter to the Ombudsman.

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

A GP Surgery in the area of Cardiff and Vale University Health Board - Clinical treatment outside hospital
Case Number: 202003406 - Report issued in November 2020
Mr X complained that he had not been informed by the Surgery ("the Surgery") of the results of tests and that calls he had made had not been returned. Mr X also said that he had not received answers to the chronic pain he had been experiencing.

The assessment found that Mr X had raised 6 points of complaint in June 2020 and a further 2 in August. Although the Surgery had responded in September, the assessment found that this had not addressed all points of complaint.

The Surgery agreed to provide a fulsome response to the complaint within 8 weeks and to send a copy to the Ombudsman.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 202002346 - Report issued in November 2020
Mr B complained that the Health Board had failed to apologise for the distress caused to him as a result of an unsubstantiated statement made in a letter sent to his GP. He also complained about the management of his complaint.

The Ombudsman concluded that appropriate action had already been taken in relation to the letter itself. However, he contacted the Health Board as he was concerned that there were missed opportunities to fully address the complaint at an earlier stage, which could have avoided it from being brought to his office. As a result, the Health Board agreed to provide Mr B with appropriate apologies and to reflect on its complaints handling to improve future service.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 202002716 - Report issued in November 2020
Mrs A complained that she suffered emotional trauma from the birth of her first child in 2017 and that the Health Board did not acknowledge any failings in care. Mrs A said that the Health Board had not listened to her or provided her with any support. Mrs A was unhappy with the Health Board's complaint response because it did not address all the issues she raised, including those relating to her son's health. Mrs A also complained that the Health Board did not respond to her request for her medical records.

The Ombudsman found that the Health Board did not provide Mrs A with her medical records. On receipt of her concerns, the Health Board did not clarify/agree with Mrs A the issues to be investigated and her complaint was not addressed in its entirety.

The Ombudsman contacted the Health Board and it agreed to provide Mrs A with her medical records and offer an apology for the delay. It agreed to allow Mrs A time to read her records and then clarify with her the outstanding concerns to be investigated. The Health Board agreed to provide Mrs A a written response to her outstanding concerns within one month.

Powys Teaching Health Board - Clinical treatment in hospital
Case Number: 202002536 - Report issued in November 2020
Mrs X's complaint relates to the care that was afforded to her husband, Mr X under the Health Board's Older Adult Mental Health Services. In particular, that he was mis-diagnosed with dementia and subsequently unnecessary medicated, with side effects, for 2 years. She explained that in September 2019, a Senior Clinical Psychologist had recommdended that Mr X attend an appointment in June 2020, for an on-road assessment and neuropsychological re-assessment. Mrs X complained that the appointment had not taken place as intended and she had concern that her husband would not remain under the care of the Senior Clinical Psychologist.

As part of its investigation, the Health Board acknowledged Mr X was not suffering with a dementia; it had withdrawn the prescription of memantine; and revised the diagnosis to Mild Cognitive Impairment. The Ombudsman took these factors into account, including that the appointment had not taken place as intended because of changes to working arrangements due to the ongoing Coronavirus pandemic. Following the Ombudsman's discussion with the Health Board, he concluded that it was appropriate for it to carry out action in resolution of the complaint.

The Health Board agreed to offer Mr X an appointment on 30 November 2020 via the NHS video call system, or telephone.

Powys Teaching Health Board - Clinical treatment outside hospital
Case Number: 202002425 - Report issued in December 2020
The complainant complained that the Health Board's Integrated Autism Service ("IAS") had failed to give her daughter the care that she needed because of her autism "within the correct timescale", to provide her and other family members with the support that they required to care for her daughter and to communicate effectively with her and her daughter.

Mrs A complained about Powys Teaching Health Board's Integrated Autism Service ("IAS"). She made this complaint in her own right and on behalf of her daughter, Ms B. She complained that the Health Board had failed to give Ms B the care that she needed because of her autism "within the correct timescale", to give her and other family members the support that they required to care for Ms B and to communicate effectively with her and Ms B. The Ombudsman noted that the Health Board had not addressed the issue of qualifying liability (this is considered to exist if it is established that a Welsh NHS body has failed in its duty of care to a patient and that the patient concerned has suffered harm as a result), in accordance with the "Putting Things Right" ("PTR") arrangements, in its written response to Mrs A's complaint. He also found that the Health Board had not explained some of the difficulties that Ms B had experienced, in terms of the service that she had received from the IAS, in that response. He considered that those deficiencies had caused Mrs A and Ms B an injustice in the form of ongoing dissatisfaction and uncertainty. The Ombudsman obtained the Health Board's agreement to send Mrs A a further written response to her complaint, which would address the issue of qualifying liability in accordance with the PTR arrangements and include the explanatory information required. He considered, as a consequence, that Mrs A's complaint had been resolved.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202003692 - Report issued in December 2020
Mr X complained that Betsi Cadwaladr University Health Board ("the Health Board") had not fully answered all his questions raised in relation to his late wife's care and treatment whilst she was an inpatient at Ysbyty Glan Clwyd.

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

By 29 December 2020

The Health Board will provide Mr X with a further written response, which specifically addresses his concerns about a delay in prescribing Fortisip liquid nutrition, its communication with him (regarding updates and the lack of information about his wife's deterioration), and the rationale for moving his wife to an Isolation room.

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

Complaints Handling

Early Resolution or Voluntary Settlement

Cardiff Council - Various Other
Case Number: 202002228 - Report issued in October 2020
Mr X complained that a Waste Management issue was responded to by the Council with no other

resolution than one at a cost to him and that there was no option available to escalate his complaint.

The Council confirmed to the Ombudsman that the initial complaint was considered as a service request and as such it agreed to the following: -

- The Council's Complaints Manger to contact Mr X, to apologise, offer him an explanation of what went wrong and how the Council will put things right. Within one week.
- The Council's Waste team to respond to his complaint. Within 20 working days.
- The Council's contact centre C2C to make sure that, if complaints are being treated as a request for service, that this is clearly communicated with its customers. Within one month.

Update the website so that when complainants are completing a complaint form, they are provided with information on exemptions to the complaints policy.

Betsi Cadwaladr University Health Board - Health
Case Number: 202002071 - Report issued in October 2020

Mr X had complained to the Health Board about his clinical treatment during 2019. He raised a concern that the Health Board had not responded to his complaint in line with the regulations.

The Ombudsman noted that Mr X had not as yet received a formal response from the Health Board, and it had not given a timescale to provide a response. The Health Board explained that it had been trying to source an external clinical view in order to respond fully to Mr X's complaint. The Health Board therefore agreed to the following:

- To obtain an independent clinical report on Mr X's complaint about his clinical care.
- To provide a copy of the independent clinical report to Mr X within two months of the date of this decision.
- To progress Mr X's complaint on the basis of the content of the independent report in line with the statutory provisions.

Cardiff Council - Roads and Transport
Case Number: 202002413 - Report issued in October 2020

Mrs X complained that Cardiff Council ("the Council") had failed to respond to the complaint that she submitted in May 2020.

In considering Mrs X's complaint the Ombudsman was concerned that the Council had not responded to Mrs X and in settlement of Mrs X's complaint the Council agreed to the following: -

By 21 October 2020

- Apologise to Mrs X for the delay in responding to her complaint and provide an explanation as to why there has been a delay
- Provide Mrs X with full response to her complaint

Hywel Dda University Health Board – Health
Case Number: 202001803 - Report issued in October 2020

Ms X complained that the Health Board had not concluded its investigation into the concerns raised about care and treatment provided to her late mother, which were raised on 6 June 2019.

The Ombudsman contacted the Health Board to discuss those concerns and enquired when it expected to be in a position to issue its response.

The Health Board confirmed that an independent expert's advice had been sought. The expert reported

that additional information should be sought to finalise its response.

Given the length of time that had passed since the complaint was received, the Health Board agreed to undertake the following: -

- Issue an apology for the delay.
- Issue its response letter no later than 4 September 2020.
- Redress payment in the amount of £50 in recognition of its delay.

The Ombudsman can confirm that the Health Board issued its response letter with the time frame agreed.

Betsi Cadwaladr University Health Board – Health
Case Number: 202002007 - Report issued in October 2020
Mr X complained to the Ombudsman that complaints he had made to the Health Board in May and November 2019 in relation to bariatric surgery he had received had not been responded to. The Ombudsman found that some aspects of the complaints he had made in May and November 2019 had been considered and reported upon during an investigation by the Ombudsman that was on-going at the time of the complaints made by Mr X to the Health Board. However, the Ombudsman determined that a number of concerns that Mr X had raised with the Health Board remained outstanding. Upon being contacted by the Ombudsman, the Health Board agreed to provide Mr X with a further specific response to the issues identified by the Ombudsman.

Specifically, the Health Board agreed that within one month of the date of this letter, it would provide Mr X with a substantive, evidence-based response to the following outstanding issues:

a) Why no mention was made to Mr X or his daughter pre-operatively to indicate that the operation was being undertaken for weight related issues.
b) Why no pre-operative counselling was given to Mr X to ensure he was fully aware of the lifelong commitment and major changes that would impact upon his lifestyle.
c) Why no pre-operative diets were implemented which is normally required for bariatric surgery.
d) Why Mr X was not cautioned that there would need to be a lifetime long strict vitamin regime.
e) Why Mr X was not alerted to the need to be given "dangerous" medications after a sleeve gastrectomy procedure.

A Medical Practice within the Cwm Taf Bro Morgannwg University Health Board area - Health
Case Number: 202002492 - Report issued in October 2020
Mrs A complained about the adequacy of a response she received from her local Medical Practice as it did not address her concerns about the care and treatment she received.

The Ombudsman was concerned that the Medical Practice did not fully address Mrs A's complaint and provided insufficient information and explanation to her.

In response to these concerns the Medical Practice agreed to undertake the following action within four weeks to resolve the matter:

a) To investigate and respond in full to Mrs A's complaint

Betsi Cadwaladr University Health Board – Health
Case Number: 202003126 - Report issued in November 2020
Mr X complained that the Health Board had not provided a complaint response in relation to his complaint about reimbursement for an mpMRI scan he had done privately.

During his enquiries, the Ombudsman established that while the Health Board had provided an apology for the delay and updates, a complaint response had not been provided. In settlement of Mr X's complaint, the Health Board agreed to complete the following within two weeks of the Ombudsman's decision letter:

a) Provide Mr X with a complaint response.

Betsi Cadwaladr University Health Board – Health
Case Number: 202002967 - Report issued in November 2020
Mrs X complained that the Health Board had not acknowledged or provided a response to her three letters following its complaint response about the care provided to her late husband.

During his enquiries, the Ombudsman established that the Health Board had not acknowledged or provided a response to Mrs X's letters at the time Mrs X made her complaint to the Ombudsman. Following the intervention of the Ombudsman, the Health Board, in settlement of Mrs X's complaint wrote to Mrs X on 26 October 2020 to:

a) Provide Mrs X with an apology for the delay in acknowledging her letters
b) Provide Mrs X with an explanation for the delay
c) Provide Mrs X with a response.

Cardiff Council - Adult Social Services
Case Number: 202002932 - Report issued in November 2020
Mr X complained that the Council had failed to provide a response to his complaint regarding his mother. The Council confirmed to the Ombudsman that it had failed to provide a complaint response to Mr X. It offered to pay Mr X the sum of £200 for the time and trouble in pursuing his complaint, and to respond to his complaint. It also agreed to complete the following in settlement of Mr X's complaint by 21 December 2020:

a) Apologise to Mr X for the failure to provide regular and meaningful updates, and for the delay in responding to his complaint
b) Provide an explanation for the delay.

Cardiff Council - Adult Social Services
Case Number: 202002916 - Report issued in November 2020
Mrs X complained that the Council had not provided a response in relation to her complaint against social services.

The Ombudsman established that the Council had not undertaken the actions previously agreed to by way of settlement. The Ombudsman also established that the Council had not provided a further complaint response in relation to additional matters Mrs X had raised. In settlement of Mrs X's complaint, the Council agreed to complete the following within two weeks of the Ombudsman's decision letter:

a) Provide an apology to Mrs X for the failure to undertake the actions previously agreed with the Ombudsman
b) Provide Mrs X with an explanation for the oversight
c) Pay Mrs X £50 time and trouble payment for having to bring her complaint back to the Ombudsman
d) Provide Mrs X with a complaint response
e) Provide an apology to Mrs X for the failure to acknowledge her recent complaint in writing
f) Provide Mrs X with a complaint response in relation to her recent complaint.

Cardiff Council - Environment and Environmental Health

Case Number: 202003418 - Report issued in November 2020

Mr X complained about the lack of a response from the Council to concerns he raised about damage to his property from a fallen tree.

The Council confirmed that while the matter had been passed to its tree inspectors no further action had been taken, and it had not responsded to Mr X's concerns.
The Council recognised its failings and agreed to undertake the following in settlement of this complaint:-

a) Issue an immediate apology for the poor communication.
b) Issue a complaint response no later than **7 December 2020**.
c) Offer a redress payment of £50 in recognition of the poor complaints handling.

Sport Wales - Community Facilities. Recreation and Leisure
Case Number: 202003312 - Report issued in November 2020

Ms X complained that Sport Wales had not responded to her correspondence concerning a complaint she raised by email on 22 September 2020.

Sport Wales confirmed to the Ombudsman that the email of 22 September had been redirected to an alternative email address within the organisation. The email had no covering content and the attachment was not clearly visible so it was deemed junk mail and deleted.

Sport Wales offered to undertake the following in settlement of this complaint: -

a) Internal staff training to be undertaken within three months to ensure all email attachments are checked.
b) Investigate and respond to the original complaint dated 22 September, no later than 30 December 2020.

Ceredigion County Council - Community Facilities. Recreation and Leisure
Case Number: 202002633 - Report issued in November 2020

Mr X complained about the way the Council handled his concerns that a caravan site had refused to renew his licence after taking his money.

In particular, he was dissatisfied that the Council attempted to discourage him from making a complaint due to the COVID-19 pandemic and failed to escalate his complaint to Stage 2 of its process.

The Council offered to apologise to Mr X and offer an explanation for his delays in escalating the complaint. It also offered to provide a substantive response by **30 October 2020**.

Wrexham County Borough Council - Adult Social Services
Case Number: 202002852 - Report issued in November 2020

Ms A complained that the Council said it was unable to investigate her complaint that the care home where her late partner Mr B had resided, had failed to respond to her complaint about his care and treatment. Ms A also complained about the lack of response from the care home in relation to missing personal items and the outstanding balance on Mr B's account.

The Ombudsman found that Mr B was a vulnerable adult who may not have been able to raise his own concerns, and although Ms A raised concerns on his behalf, she did not receive a response from the care home or the Council. The Council said that whilst it recognised that Ms A was close to Mr B, she was not be legally entitled to detailed personal information (without consent or Lasting Power of Attorney), and therefore could not raise a complaint on his behalf.

The Ombudsman considered that Ms A was entitled to complain about the issues where she was directly affected, (the lack of a complaint response from the care home) and, that she was entitled to complain about the care and treatment of Mr B. If the Council maintained the view that it was unable to disclose personal information about Mr B to Ms A, it remained possible for it to investigate Ms A's concerns and provide her with a general complaint response.

In settlement of the complaint, the Council agreed to investigate Ms A's concerns and provide her with a written response, and to provide an account to the Ombudsman of the action taken.

Conwy County Borough Council - Adult Social Services
Case Number: 202002782 - Report issued in December 2020

Ms A complained about Conwy County Borough Council ("the Council") Social Services department. Ms A said that a social worker had not included her in discussions about her father and ignored her father's wishes to be included. Ms A also said that the Council failed to liaise with her about financial matters relating to her father.

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 Stage 2 investigation into Ms A's complaint. The Council also agreed to make a redress payment of £50 to Ms A.

Carmarthenshire County Council - Planning and Building Control
Case Number: 202003141 - Report issued in December 2020

Mr A complained that the Council failed to respond to his request for specific information and provide a formal apology following its decision to uphold his Stage 2 complaint.

Although the Council subsequently provided a response and an apology, the Ombudsman contacted the Council, as he was concerned that there had been an avoidable delay and were systematic communication issues between departments. Mr A had also not been kept informed and was required to submit a complaint to his office before receiving a response. There was no evidence that the Stage 2 report's recommendations had been complied with.

As a result, the Council agreed to provide Mr A with a time and trouble payment of £250, to use the complaint as a learning tool to improve future service, to create an escalation procedure to prevent delays from occurring and to provide evidence of the action taken in response to the Stage 2 report's recommendations.

Conwy County Borough Council – Safeguarding
Case Number: 202003396 - Report issued in December 2020

Mr D complained about Conwy County Borough Council's ("the Council") conduct in its administration of a Child Protection Strategy Meeting, and its subsequent refusal to investigate his complaint about these matters.

The Ombudsman found that the Council had refused to investigate Mr D's complaint in accordance with guidance produced by Welsh Government. However, Mr D subsequently provided supporting evidence to the Council to demonstrate that the guidance was not applicable in the circumstances. Despite Mr D writing to the Council on three separate occasions following its refusal to investigate, the Council failed to provide him with a response.

The Ombudsman contacted the Council and it agreed to:

by 24 December 2020:

- Provide a written apology to Mr D for the failure to respond to his communications.
- Investigate and respond to Mr D's complaint about the alleged procedural irregularities connected to the Child Strategy Meeting.

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

Pobl – Housing
Case Number: 202003516 - Report issued in December 2020
Mr X complained that the Association had failed to provide a response to his complaint regarding outstanding work to his garden.

The Association confirmed to the Ombudsman that it had failed to provide a complaint response to Mr X and its communication had been below an acceptable level. The Association agreed to complete the following in settlement of Mr X's complaint by 5 January 2021:

- Apologise to Mr X for the failure to provide regular and meaningful updates, and for the delay in responding to his complaint
- provide an explanation for the delay
- provide a complaint response.

Betsi Cadwaladr University Health Board – Health
Case Number: 202003748 - Report issued in December 2020
Mrs X complained that the Health Board had failed to fully respond to her complaint about the treatment provided to her late father, which she initially made to it on 15 June 2020.

By 11 January 2020

- Apologise to Mrs X for the delay in responding to her complaint
- Provide Mrs X with a follow-up response to her complaint

A GP Surgery in the area of Betsi Cadwaladr University Health Board – Health
Case Number: 202003817 - Report issued in December 2020
Mrs X complained that a GP Practice ("the Practice") in the area of Betsi Cadwaladr University Health Board ("the Health Board") had failed to respond to her complaint about the care it provided to her late mother, Mrs Y.

The Ombudsman found that the complaint had been made to the Practice in May **2019** and the Practice had met Mrs X to discuss her concerns in September. Mrs X said at that meeting that she had concerns about the Health Board's treatment of Mrs Y. The Practice failed to advise Mrs X that her concerns about the Health Board should be made directly to it, and did not provide a response to her about its own treatment of Mrs Y. The Practice also failed to provide regular, meaningful updates to Mrs X. These failures constituted a significant injustice to Mrs X, given the unacceptable wait she had endured for a response to her concerns.

The Practice agreed to apologise to Mrs X, provide her with a response regarding the care it provided to Mrs Y, and to make a £250 payment to Mrs X for her time and trouble in making her complaint and in recognition of the failings identified, by 28 January **2021**. It also agreed for relevant staff to undergo complaint handling training by 29 March.

Welsh Ambulance Services NHS Trust - Various Other
Case Number: 202003563 - Report issued in December 2020
Ms W complained that the Welsh Ambulance Services NHS Trust ("the Trust") did not respond to a

complaint she submitted ten months earlier. Ms W also complained that even though she sent correspondence on two further occasions, the Trust did not respond.

The Ombudsman was concerned that the Trust failed to acknowledge or respond to Ms W's complaint. In response to these concerns the Trust notified the Ombudsman that it had identified an error in its process and offered to undertake the following action withn 21 days to resolve the matter:

a) To apologise to Ms W for its lack of communication
b) To respond in full to Ms W's concerns
c) To pay Ms W £200 for the inconvenience caused by its service failure
d) To implement a new administration process to prevent a recurrence of its service failure

Education

Early Resolution or Voluntary Settlement

Neath Port Talbot Council - School Transport
Case Number: 202003378 - Report issued in December 2020
Mrs A complained to the Ombudsman that the Council and its School Transport Appeals Panel ("the Panel") failed to acknowledge her son, B's, complex physical and mental health needs when it said that he was not eligible for school transport, because he did not meet criteria for exceptional circumstances under Section 4 of the Learner Travel (Wales) Measure 2008 ("the Measure"). Mrs A said that the decision placed B at a significant disadvantage in comparison to a child without a disability, of the same age accessing comprehensive school. Mrs A asked the Council to take into consideration the difficulties presented by the current COVID-19 pandemic in obtaining written information from health professionals to support her application.

Under Section 4 of the of Measure, if a learner of compulsory school age cannot walk (accompanied or unaccompanied) to their nearest suitable school, because of a disability or learning difficulty which they have, even if the distance to their nearest suitable school is less than the statutory limit for their age group, there is a duty placed on the Council to make suitable travel arrangements for that child. Whilst the Council recognised that B was unable to travel alone, it was not evident that it had fully considered the impact of his mental and physical health needs on his ability to safely walk to school, even if accompanied and that it would be unreasonable to expect him to do so. From the information available, the Council did not appear to give due consideration to the difficulties Mrs A had in obtaining written information to support her application.

The Ombudsman contacted the Council and it agreed to allow Mrs A the opportunity to obtain further written information, and on receipt of the information, convene a Panel within 30 working days for it to consider B's eligibility for school transport.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

Gwynedd Council - Noise and other nuisance issues
Case Number: 202003258 - Report issued in November 2020
Mr X complained that the Council's Bins and Recycling Service constantly arrived at his house between 5:55am and 6:20am despite the fact that they are not supposed to leave the yard until 6:30am. Mr X considered the noise caused by the vehicles to be a nuisance. Mr X complained that this was a

reoccurrence of a problem the Ombudsman had looked at previously. Mr X was also aggrieved at the mess that the Service would leave after collection. Mr X complained several times to the Council about this, but had not received a response.

In the Council's response to the Ombudsman's office, the Service acknowledged that they had not formally responded to the complaint made in 2019. The Council said that the Service apologised for this error. The Service explained that in 2019 it undertook to change its working arrangements, meaning that staff would not leave the depot before 6:00am, these changes were ongoing at the time of the original complaint. All affected residents had received a letter informing them of the change to its working arrangements. The Service also indicated that, due to the Covid19 situation, they had to alter their working arrangements in order to ensure that they complied with the relevant regulations, but that they had not informed Mr X of this.

In settlement of Mr X's complaint, the Council has agreed to formally respond, by 23 December 2020, to his complaint and to address his issues of concern.

Housing

Early Resolution or Voluntary Settlement

Clwyd Alyn Housing Association - Neighbour disputes and anti-social behaviour
Case Number: 202001687 - Report issued in October 2020
Mr X complained that the Housing Association had failed to assist with a complaint of anti-social behaviour; it had instead relied on other bodies to take action.

The assessment found that the Housing Association had not been unreasonable to adopt a multi-agency approach. The complaint concerned alleged noise nuisance, evidence of which needed to be gathered to the appropriate standard by the Local Authority.

However, as the gathering of evidence was essential to the determination of nuisance, the Ombudsman agreed with the Housing Association that it would work proactively with the Local Authority with a view to securing installation of noise monitoring equipment within 4 weeks. Also, that within 7 days of receipt of the noise report, the Housing Association would confirm in writing what, if any, further action it proposed to take in relation to the complaint and the reasons for that. Finally, the Housing Association said that it would send a copy of that letter to this office within 10 days of the outcome from the Local Authority.

Trivallis - Other
Case Number: 202001950 - Report issued in October 2020
Mr A complained that the Housing Association had failed to investigate issues reported to it regarding a neighbour sub-letting his property and then allegedly purchasing the property under the Welsh Government's Right to Buy scheme.

Mr A had referred the complaint to the Ombudsman after receiving a response from the Housing Association at stage 1 of its complaint procedure. At that time the Ombudsman had referred the complaint back to the Housing Association in order for it to have the opportunity to respond under stage 2 of its procedure.

It became apparent that the Housing Association had failed to respond to this in a timely manner and when the complainant received the response he escalated his complaint to the Ombudsman again.
The Ombudsman assessed Mr A's complaint. It was found that the issues he had raised in his complaint regarding the Right to Buy scheme were likely to be criminal matters that the Ombudsman was unable to

consider.

It was considered, however, that the failure to respond to Mr A's complaint at stage 2 in a timely matter amounted to maladministration by the Housing Association. There was also concern that the Housing Association's complaint procedure failed to provide timelines to manage complainant's expectations of when they were likely to receive a complaint response from it.

The Ombudsman contacted the Housing Association regarding this issue.

The Housing Association agreed:

To write a letter to the complainant

a) Apologising for the delay in responding to him at stage 2 of its complaint procedure
b) Offer him a payment of £125 in recognition of the time and trouble taken by him in pursuing his complaint
c) Undertake a review of its complaint procedure to include the provision of reasonable timelines for responding to complainants.

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

The Ombudsman believes that the action promised by the Housing Association will resolve this complaint.

Cardiff Council - Applications. allocations. transfer and exchanges
Case Number: 202002142 - Report issued in October 2020

Mr A complained that Cardiff Council ("the Council") did not respond to several concerns he raised about its management and administration of two homelessness housing applications he had submitted.

The Ombudsman was concerned that the Council failed to address several areas of concern raised by Mr A and had considered the matter to be closed.

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

a) To review all aspects of Mr A's complaint and respond in full

b) To provide a fulsome apology for any distress its actions had caused to Mr A and his family

Hafod Housing Association - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202002707 - Report issued in November 2020

Mrs X complained that Hafod Housing Association ("the Association") had not made repairs to her property which Mrs X said has damp walls, which are affecting her health. She also complained that the Association failed to respond to her numerous complaints, and she feels ignored by them.

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

- By 31 November, the Association will provide Mrs X with a written response responding to her concerns and apologising for the delay in its response. It will also explain what works will be conducted and the dates to address Mrs X concerns. It has also agreed to contact Mrs X to discuss an offer of compensation for the inconvenience she has experienced.

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

Clwyd Alyn Housing Association - Neighbour disputes and anti-social behaviour
Case Number: 202001750 - Report issued in November 2020

Miss A, a tenant of Clwyd Alyn Housing Association, complained about the antisocial behaviour of another tenant. Miss A completed noise nuisance complaint forms but was not kept informed regarding procedures or progress of her complaint. Miss A was unhappy with the complaints handling and with the time taken to deal with the issues raised.

The Ombudsman declined to investigate. Miss A's concerns were not dealt with in accordance with the Housing Association's Antisocial Behaviour Policy and Procedures and assessments were not undertaken. Miss A was not provided with any support and the Housing Association did not listen to the available noise recordings. The Housing Association had processed a complaint from another tenant, which incorporated the concerns, but Miss A was not contacted and only limited information was provided in response to her formal complaint. This left Miss A unaware of any steps being taken to resolve the issues or any progress made.

The Housing Association agreed to, within 20 working days, provide Miss A with an apology for the noise nuisance forms not being processed in accordance with its Antisocial Behaviour Policy and Procedure, for the lack of communication and for its failure to listen to noise recordings. The Housing Association also agreed to provide an explanation as to why they could not obtain the recordings from Ms A and to review its Antisocial Behaviour Policy and Procedures to ensure they meet the needs of all tenants.

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

Coastal Housing Group Ltd - Other
Case Number: 202002258 - Report issued in December 2020

Miss A complained about estate rent and service charges demanded by the Housing Association. Miss A disputed payment as she had not received a service and previous charges had been written off. Miss A was unhappy that she was not informed that arrears were accruing and considered the correspondence chasing payment to be harassing.

The Ombudsman declined to investigate. Miss A was obliged to pay the estate rent charge and the services charges under covenants entered into on the purchase of the property. The tone and content of correspondence was not considered harassing and the enforcement action outlined did not appear unreasonable. A service appeared to have been provided in relation to the communal areas. However, the Housing Association had historically been inconsistent in its communication with Miss A, had not undertaken audited accounts and failed to provided Miss A with a summary of the costs, charges and expenses incurred.

The Housing Association agreed to within 20 working days provide an apology for its poor communication and its failure to undertake audited accounts and provide a summary to Miss A. It agreed to provide a full written explanation as to why the charges apply, details of amounts previously written off, why payments were not chased, details of charges outstanding and how they had been calculated. The Housing Association also agreed to within 30 days review the position in relation to the preparation of audited accounts for individual properties and to provide Miss A with details of how future charges will be calculated and how and when she will be informed of those charges. The Ombudsman's view was that this action was reasonable to settle Miss A's complaint.

United Welsh Housing Association – Other
Case Number: 202002529 - Report issued in December 2020

Miss H complained that the Housing Association had failed to share vital information which led to her house being cleared and her possessions being disposed of before she had an opportunity to identify anything that might have been salvageable following a devastating fire.

The Ombudsman found that there was a service failure which arose from a communication breakdown within the Housing Association as a result of the unexpected and unusual situation caused by the outbreak of Covid-19 and the furlough of staff, including Miss H's allocated Housing Officer. Consequently, Miss H believed that her home would not be cleared for some time and that she would be contacted in advance, while the Insurance Company and its appointed contractors believed that Miss H had already had time to return to her property to go through her possessions. The Housing Association had recognised this failure, accepted responsibility for it and offered apologies. It had also offered a goodwill payment of £500 to reflect the service failure that had occurred, although this had been withdrawn after Miss H refused it.

The Ombudsman is unable to consider matters of legal liability and compensation, such as how much of Miss H's removed property was (or was likely to have been) salvageable, or its value. It was appropriate for these issues to be considered by an insurance claim and/or through the courts. The Housing Association agreed to re-offer its goodwill gesture of £500, within 1 month of the date of the Ombudsman's decision, in settlement of the complaint. The Ombudsman thought that this action was reasonable and considered the matter to be settled on this basis.

Roads and Transport

Early Resolution or Voluntary Settlement

Newport City Council - Parking

Case Number: 202002549 - Report issued in October 2020

Mr X complained that Newport City Council ("the Council") had rejected his application for a parking permit because his address did not match the street where the permit bay is. Mr X says his front door is less than two meters from the parking bay.

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

By 18 November 2020:

- The Council should provide Mr X with a formal complaint response which provides a more detailed explanation about its eligibility criteria and its consideration of Mr X's application for a parking permit.

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

Vale of Glamorgan Council - Road maintenance/road building

Case Number: 202002052 - Report issued in October 2020

The complainant said that there was a discrepancy between maps held by the Council and her father concerning a transfer of land between them. The complainant felt that a section of the land was not in her father's ownership and that the Council should repair it.

The assessment found that it was a matter for the Council if it considered that the correct position was that shown on the plan attached to the transfer it held. It would be for the family to decide if they wished to pursue the matter on a legal basis.

However, as it seemed that the matter might have been ongoing for some time which may have caused some limited injustice, the Council agreed to provide a definitive statement of its position on the matter within 8 weeks, if possible. It would also facilitate any reasonable further queries the family may have about the transfer of the land.

Social Services – Adult

Upheld

Isle of Anglesey County Council - Services for vulnerable adults (eg with learning difficulties. or with mental health issues)
Case Number: 201904391 - Report issued in November 2020

Mr P complained about the Council's handling of a complaint that he made about the circumstances that led to his late brother, Mr A (a vulnerable person with learning disabilities), changing his will in favour of carers employed/commissioned by the Council. Mr P complained that the Council declined to disclose a full copy of a Stage 2 investigation report into his concerns, on data-protection grounds. Mr P also questioned whether the Council had implemented any of the recommendations set out in the Stage 2 report.

The Ombudsman found that the Council's initial decision to decline to conduct a Stage 2 Investigation under the Social Services Statutory Complaints Procedure had been based on its view that there had been no social services involvement in the management of Mr A's finances and that the regulations governing Stage 2 investigations did not apply to Care Support Workers commissioned by the Council. The Ombudsman determined that both of these rationales were incorrect and, following his intervention, a Stage 2 investigation was conducted. The Ombudsman considered that it was an injustice to Mr P to have to seek the Ombudsman's intervention on this matter and, on this basis, partially upheld this complaint.

The Ombudsman did not uphold the other complaint elements as he found that the Council's decision not to disclose the Stage 2 report in full to Mr P was taken in accordance with Data Protection regulations and that the Council had implemented the Stage 2 investigation's recommendations.

The Ombudsman recommended that Mr P should receive an apology and a payment of £150 for the inconvenience he encountered. The Ombudsman also asked the Council to reflect on the fact that it did not explain the data Protection regulations governing its decision not to disclose the report in sufficient detail to Mr P.

The Council accepted the Ombudsman findings and recommendations.

Early Resolution or Voluntary Settlement

Cardiff Council - Complaints Handling
Case Number: 202002641 - Report issued in November 2020

Ms X complained that the Council failed to effectively investigate and respond to issues raised concerning her late mother in February 2020.

The Council recognised that whilst it was moving its resources to the frontline to help manage the public during the COVID-19 pandemic, Ms X did receive a poor service. It therefore offered to undertake the following to resolve this complaint: -

a) Make a £300 redress payment for the distress Ms X has experienced in using its service, with its apologies.
b) Issue its formal Stage 1 response within 15 working days.

Social Services – Children

Early Resolution or Voluntary Settlement

Carmarthenshire County Council - Safeguarding
Case Number: 202001837 - Report issued in October 2020
Ms X complained that the Council subjected her to an unnecessary intervention, during which staff relied on "flawed and inaccurate information" to suggest that her daughters may be subjected to Female Genital Mutilation. Ms X said that although the complaint was independently investigated, the response was unsatisfactory.

The assessment found that the independent investigation was generally of an appropriate standard and reached reasoned conclusions.

However, the assessment found that the independent investigator ("II") did not interview Ms X's partner and father of the children. The Council agreed to write to the II within one month to remind him of the important of including relevant adults, particularly those with parental responsibility, in the investigation process. The Council also agreed to write to Ms X within one month with further information about the learning opportunities it would be providing to staff as a result of the complaint, further to the II's recommendation.

Various Other

Early Resolution or Voluntary Settlement

Denbighshire County Council - Tender (for out-sourced services)
Case Number: 202001848 - Report issued in October 2020
Ms X complained on behalf of Mr Z that the Council failed to meet its statutory obligations with regards to its tender process for the School and Social Services Transport Services for Private Hire Contact. Mr Z said he lost his license as it did not consider the process fairly.

The Council responded under Stage 1 of its complaints process but due to the then COVID-19 lockdown restrictions it was not in a position to escalate the issue to Stage 2 until "business critical activities" ceased. Once the national emergency was passing the Council agreed to respond to the substantive issues by 25 September 2020.