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PUBLIC SERVICES OMBUDSMAN FOR WALES

The Ombudsman's Casebook

Issue 44 January – March 2021

Contents

Public Interest Report Issued: Upheld

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201807774 - Report issued in January 2021

Miss Y complained on behalf of her partner, Mr X, that there was a failure to accurately diagnose his cancer between February and June 2018.Mr X had been first seen at the Royal Gwent Hospital ("the Hospital") in February, and had undergone tests including an MRI scan in June(MRI" – the use of strong magnetic fields and radio waves to produce detailed images of the inside of the body). On reviewing the MRI (at a Multi-Disciplinary meeting – "MDT" - in July) the Hospital told Mr X that his cancer was organ confined to the prostate. It was recommended he undergo a RALP (a prostatectomy – removal of the prostate gland), which was performed on 25 September. On a subsequent Hospital review of the MRI imaging, Mr X was told in November that his cancer was being upstaged and that it was not organ confined. It had spread outside the prostate. Mr X was told that the MRI scan in June had missed this. Miss Y complained that the Hospital had missed the extent of Mr X's cancer on the original scan leading to him undergoing the unnecessary RALP, which had resulted in him suffering debilitating side effects. Further, she said that Mr X was not able to properly consent to the RALP procedure, not being in possession of the full facts, or therefore having the opportunity to consider any alternative treatments.

The investigation identified numerous failings in Mr X's care in the period concerned. These included the following: a failure to note enlarged pelvic lymph nodes on the June scan, which were suspicious, and so incorrectly staging them and reporting them as being normal; only one view had been taken whereas an axial sequence should have been performed in accordance with recognised guidance (which may have better identified the pelvic nodes as suspicious); the suspicion of metastatic cancer should have been raised from a lesion's appearance (its size passing the threshold of suspicion); the MDT record in July was insufficient, so that it was not possible to discern if all the images and reports had been considered at the meeting. There was no clear evidence that Mr X was informed about possible alternative treatments to the RALP and, given the above failings, he consented to and underwent an unnecessary procedure (a RALP is only suitable for patients with organ confined cancer), so suffering the severe after effects he complained about. This was a significant injustice to him. From advice received during the investigation, nevertheless, the failings were unlikely overall to have significantly altered Mr X's overall prognosis, but the failings found were significant ones and the complaint was upheld.

The following recommendations were made, which the Health Board agreed to implement over a period of 6 months:

a) Apologise to Miss Y and Mr X for the identified failings.
b) Make a redress payment of £5000 to Mr X for the failings in his care.
c) Remind all clinicians about properly documenting the meeting/preparing minutes of MDTs.
d) To review its prostate MRI protocol to ensure a pelvic sequence view is taken (as per guidance to better allow for pelvic lymph node evaluation).e) To provide evidence of the review of MDT meeting arrangements the Health Board indicated it had since introduced, to the Ombudsman.
e) Consider an MDT review of all prostate cases (from June 2018 to the present day) where subsequent pathology placed the patient in to a higher risk category from the initial staging.
f) Reviews its MDT procedure to consider implementing a routine audit of MDT reporting against pathology outcomes.

Cwm Taf Morgannwg University Health Board & Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 201905294 & 202000972 - Report issued in January 2021

Mrs W complained about the care provided to her husband, Mr W, by Abertawe Bro Morgannwg University Health Board, following his oesophageal (relating to the food pipe between the throat and stomach) cancer surgery in February 2018. Mrs W said that Mr W never really recovered after his surgery; he struggled to eat and became emaciated, immobile, incontinent and depressed. Although palliative support was eventually arranged, this was only arranged just 2 weeks before Mr W died in September 2018. The Ombudsman found that Mr W should have been given psychosocial support and specialist dietetic support before, during and after his surgery. He was unable to reach any conclusions about whether the frequency and standard of telephone support offered by a Specialist Nurse was clinically appropriate because no records were maintained. During the same period, Mrs W also approached a charity for support and wrote twice to the Health Board to request contact, explaining that Mr W was very unwell, rapidly losing weight and struggling to eat. In addition, a Dietician identified that Mr W was malnourished and lost 19% of his bodyweight. No action was taken by the Health Board until Mrs W escalated her concerns to the NHS Wales Chief Executive, which should not have been necessary in light of Mr W's prognosis and his deteriorating condition. The Ombudsman therefore concluded that there was no evidence that the Health Board provided adequate and appropriate post-discharge care and support to Mr W and that it had failed to deal with Mrs W's requests for contact and support promptly.

He also found that Mr W and his wife were not advised on symptoms of recurrence or informed of Mr W's prognosis after an analysis of the tissue removed during his surgery indicated that Mr W's cancer had not been fully removed. There was no evidence that Mr and Mrs W were told of the high likelihood that Mr W's cancer would recur and that, if it did, it would probably be systemic. Therefore, the Ombudsman concluded that the Health Board failed to keep Mrs and Mr W fully informed about Mr W's condition, his prognosis and what to expect. The evidence in this case and in previous cases considered suggested that this failure was the result of a systemic issue relating to full and appropriate communication with patients, across the Health Board area.

The Ombudsman also found that, whilst Mr W's terminal diagnosis was not apparent until his symptoms recurred, palliative care should have been offered once the outcome of the surgery, and Mr W's poor prognosis, was known. The failure to do so meant that Mr and Mrs W were unable to access appropriate support and review promptly when Mr W's symptoms did recur. As a result, the Ombudsman found that the Health Board failed to provide suitable end-of-life care to Mr W.

After the events leading to this complaint, changes took place to NHS provision in the local government area of Bridgend, which was transferred from the former Abertawe Bro Morgannwg University Health Board (re-named Swansea Bay University Health Board) to the former Cwm Taf University Health Board (re-named Cwm Taf Morgannwg University Health Board). Swansea Bay and Cwm Taf Morgannwg agreed to implement the Ombudsman's recommendations respectively.

The Ombudsman recommended that, within 1 month of the date of this report, both Swansea Bay and Cwm Taf Morgannwg should:

a) Provide an apology to Mrs W for the shortcomings identified in this report.
b) Share this report with all staff throughout the relevant service areas, for them to reflect on the findings and conclusions.
c) He also recommended that, within 3 months of the date of this report, both Swansea Bay and Cwm Taf Morgannwg should:
d) Review current practice on the recording of telephone support offered by the Specialist Nurse Service, to ensure that it is compliant with the NMC Code and standards on record keeping and remind all relevant staff of those standards.
e) Conduct a random sampling Patient Opinion Survey to establish an understanding of patients' experiences of UGI cancer care. Repeat this survey a year later to establish whether there has been any improvement and, if any issues around communications are identified as prevailing, take further steps to address them.

f) Further, he recommended that, within 6 months of the date of this report both Swansea Bay and Cwm Taf Morgannwg should:
g) Ensure that the first Surgeon, the second Surgeon, the Oncologist and the Specialist Nurse consider and reflect on my findings as part of their regular supervision.
h) Implement compulsory training for all doctors and nurses treating and managing patients with gastro-intestinal cancer, covering advanced communication skills and the need for patient involvement in care, including exploring patients' expectations and values around their personal diagnosis and prognosis, as well as the human rights issues identified in this case.
i) Take steps to ensure that patients with upper GI cancer have access to nutritional assessment, tailored specialist dietetic support and psychosocial support, in line with the NICE guidance.
j) Finally, the Ombudsman recommended that, within 9 months of the date of this report:
k) Swansea Bay should consider the care in this case through a process akin to that provided in the Complaints Regulations, to decide whether there is any qualifying liability arising from any harm that arose from any breach in the Health Board's duty of care as a result of the failings identified.
l) Within 6 months of reminding relevant staff of the NMC standard of record keeping, both Swansea Bay and Cwm Taf Morgannwg should conduct an audit of a reasonable sample of Specialist Nurse records in the service, to determine the standard of compliance with NMC Code and take action to address any shortcomings.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case Number: 201900746 - Report issued in February 2021

Mr A complained about the care that his late mother Mrs B, received at Betsi Cadwaladr University Health Board's ("the Health Board") Glan Clwyd Hospital ("the Hospital"). In particular, he said that when it came to the management and care of his mother's severe rectal prolapse (a rectal prolapse occurs when part of the rectum (back passage) protrudes through the anus), there had been surgical delays by the Colorectal Department going back to 2011. Mr A queried the adequacy of the inpatient medical care provided by a Care of the Elderly Consultant during Mrs B's admission in May 2018 and had concerns about a delayed diagnosis of his mother's terminal ovarian cancer during this admission. Mr A was also dissatisfied with the robustness of the Health Board's complaint response.

The investigation found consistently from 2011 onwards, that in terms of Mrs B's rectal prolapse management, the clinical decision-making and rationale shown by the Colorectal Surgeons was not in keeping with accepted clinical practice. More straightforward surgical rectal prolapse repair options, including less invasive procedures, were discounted in favour of high risk, unconventional and in one case (which would have involved the complete removal of Mrs B's rectum and possibly her anus), extreme treatment options, which would have provided Mrs B with little or no clinical benefit.

Mrs B was initially reluctant to have either a colostomy (where the colon is brought up to the surface of the skin and the bowel opened to form a stoma so the bowel contents can be collected in a stoma bag), or a complete removal of her rectum. As these procedures were the only rectal prolapse treatment options offered to her from 2011 onwards, this was a further factor in the delay.

The Ombudsman was critical of the lack of clinical clarity demonstrated in Mrs B's case. The mixed messages given to Mrs B concerning the benefits of a colostomy meant it was only on the day of the operation, in March 2018, that she was told definitively the procedure would not benefit her prolapse. Mrs B decided not to go ahead with the operation.

As a result of the failings identified, Mrs B had to endure years of indignity on a daily basis as she dealt with her severely symptomatic prolapse and the accompanying bowel and urinary incontinence. Since 2014, Mrs B had been living with dementia. Mr A referred to his mother being effectively housebound for the last 8 years of her life and being unable to take up social opportunities, including those recommended by the Memory Clinic for her dementia, in case she was "caught short" due to her double incontinence. Whilst the Ombudsman does not have the power to make definitive findings about whether there have

been human rights breaches, he was clear that Mrs B's human rights in relation to Article 8 (which includes the right to respect for private and family life) were engaged as a result of the failings found. He noted that opportunities for Mrs B to develop and maintain her personal identity through external social interactions/relationships were considerably hampered. The family's relationship with Mrs B and the quality of the time that they spent together were also affected by her rectal prolapse condition and its wider effect, including the uncertainties around Mrs B's treatment and management. The Ombudsman concluded that the indignity of Mrs B's condition and the longstanding physical and mental impact the failings had on her and her family caused significant injustice to Mrs B. This part of Mr A's complaint was upheld.

In relation to Mrs B's last inpatient admission, and whether her ovarian cancer diagnosis could have been made sooner, the Ombudsman was satisfied on the evidence that Mrs B's general management and care was appropriate and her ovarian cancer could not reasonably have been diagnosed earlier than it was. Therefore, this aspect of Mr A's complaint was not upheld.

Finally, the Ombudsman's investigation found that the Health Board's complaint response should have identified the extent of the failings when it came to clinical decision-making by the Colorectal team and Mrs B's delayed rectal prolapse repair. He concluded that the Health Board had missed opportunities to fully learn from Mrs B's case. The Ombudsman considered the distress and added inconvenience of having to make a complaint to the Ombudsman's office caused Mr A and the family an injustice. This part of Mr A's complaint was upheld.

The following recommendations were made to be carried out over a 3 month period:

a) The Health Board's Chief Executive should apologise to Mr A, on behalf of the family, for the clinical and complaint handling failings identified.
b) The Health Board should invite Mr A and his sister to engage with an equivalent to the Putting Things Right Redress process via its Legal and Risk Services Team.
c) The Health Board should review how its Colorectal team carries out rectal prolapse procedures.
d) The Health Board should share the points of clinical learning from this case at an appropriate colorectal clinical forum.

The Health Board agreed to implement the above recommendations.

Covid

Early Resolution or Voluntary Settlement

Blaenau Gwent County Borough Council - Other
Case Number: 202003819 - Report issued in February 2021
Complainant complained about Blaenau Gwent County Borough Council (the Council") and the requirement that he wear a face mask during contact with his children. He said that he was exempt due to asthma and anxiety and that wearing a mask during contact affected his health, causing him to struggle with his breathing in the days following contact sessions. The Council asked him to provide evidence of his medical condition and, if not wearing a mask, required him to remain 3 metres away from his children during contact, both indoors and outdoors. Complainant considered that the Council's Face to Face Contact Guidance (the Guidance") discriminated against him because of his health issues and breached his human rights. The Council refused to accept the complaint on the basis that it was a properly made decision in line with its policy.

The Ombudsman found that the Council could have considered the complaint, but it may not have

achieved are solution for the complainant, as the decision was consistent with the Council's Guidance in place at the time.

The Ombudsman considered that the Council's Guidance may not be compliant with Welsh Government Regulations and Guidance or with relevant equalities and human rights legislation. The first version of the Guidance did not consider the exceptions to wearing face coverings. The second version requires parents refusing to wear a face covering to provide evidence of exemption. The Guidance appears to treat all individuals refusing to wear a face covering in the same way and fails to take account of an individuals' circumstances. This blanket approach appears to result in Mr A being treated differently from other service users as a result of his condition. It is unclear how the Council had decided that parents not wearing masks remain 3 metres away from their children and Mr A did not appear to have been given an explanation about the reasons for this requirement. The Ombudsman was not satisfied that the Council had sufficiently demonstrated consideration of human rights in this case as the Guidance did not seem to allow for individual assessment on a case by case basis.

The Ombudsman contacted the Council and it agreed to review the Face to Face Contact Guidance to consider whether it complied with Welsh Government Regulations and Guidance and equalities and human rights legislation. The Council agreed to review the decision and provide Mr A with a written explanation of its decision, within 10 working days of the review. The Ombudsman was satisfied that this would provide a resolution to the issues considered in this complaint.

Health

Upheld

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201900607 - Report issued in January 2021

Mrs A complained that Cwm Taf Morgannwg University Health Board ("the Health Board") failed to provide timely follow-up after an ophthalmology appointment in May 2016. Mrs A said that she was not seen for over 2 years and, during that time, she developed neovascularisation (changes associated with diabetic retinopathy that affect the blood vessels in the eyes) that required laser treatment. In her view, the changes could either have been prevented or reduced through earlier intervention.

The Ombudsman found that the Health Board had failed to provide Mrs A with a timely follow-up ophthalmology appointment. However, there was no delay in identifying the changes to her eyes which developed after the next follow-up appointment had taken place. Accordingly, the Ombudsman did not uphold Mrs A's complaint.

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Mrs A complained about significant delays by Cwm Taf Morgannwg University Health Board ("the Health Board") when fitting and supplying her orthotic boots (custom made to meet the individual medical needs of the patient). Mrs A said that there was a failure to take account of her complex needs, and to adopt a multidisciplinary approach to her care. Mrs A also said that the Health Board was slow to respond to her concerns when she raised them.

Mrs A had complex footwear needs and the records showed that her orthotic boots required multiple fittings and necessary changes to the specification to achieve a good fit. However, the Ombudsman found that the following failings contributed to unreasonable delays before Mrs A's boots were supplied:

- the failure to take account of a significant change in her clinical presentation at her first review

appointment
- the failure to take timely action to order the second pair of boots to which she was entitled
- the failure to adopt a multidisciplinary approach to her care at an earlier time
- multiple manufacturing errors causing the boots to be returned for further adjustments
- the failure to implement a sufficiently robust quality management system to identify the reason for manufacturing errors
- the failure by the private company providing the orthotic service for the Health Board to meet the timescales for product provision set out in the service contract
- ineffective performance monitoring with insufficient focus on patient outcomes.

The Ombudsman also found that the Health Board was slow to respond to the complaints that Mrs A raised about the fit of her footwear and the delays she was experiencing. As a result of the delays, before Mrs A was provided with a well-fitting pair of boots, she experienced unnecessary clinic attendances over a protracted period, avoidable foot injury and pain, and emotional distress due to concerns about more serious complications arising from her diabetes.

The Ombudsman upheld Mrs A's complaint and he made several recommendations to put matters right. The Health Board agreed within 1 month to apologise to Mrs A and to make her a redress payment of £1000 in recognition of the impact of the failings on her. The Health Board also agreed within 6 months to remind its orthotists of the importance of arranging timely multidisciplinary input as a part of clinical decision making for patients with more complex needs, and to share the findings with the National Contracting Body and the private company providing the orthotic service on its behalf with a view to reviewing the service specification, performance measures and aspects of the quality management system.

Commendably, in response to a suggestion made by Mrs A, the Health Board also offered to develop a patient information page on its website, and generic patient advice cards to include with its orthotic products.

Betsi Cadwaladr University Health Board - Health
Case Number: 201902099 - Report issued in January 2021

Mr Q complained about Betsi Cadwaladr University Health Board's failure to provide adequate care and treatment for his wife, Mrs Q, that resulted in multiple admissions to hospital between 28 March and 20 June 2018. Mr Q was also unhappy about the failure to create and implement an appropriate care plan for Mrs Q. Mr Q also complained about the Health Board's poor complaint handling practices.

The Ombudsman's investigation found that whilst Mrs Q was treated appropriately and symptomatically during her several hospital visits, during her visits on 2 May, and in particular 20 June when the Emergency Department ("ED") was extremely busy and Mrs Q had to wait 7 hours to be seen, communication between staff and Mr and Mrs Q was poor which left Mrs Q upset and Mr Q confused. The Ombudsman upheld this part of the complaint.

The Ombudsman also found that the Health Board failed to arrange a meeting between Mr and Mrs Q and appropriate Health Board staff despite receiving a request from an advocate on behalf of Mr and Mrs Q. The Ombudsman upheld this part of the complaint as an opportunity to address Mr and Mrs Q's concerns was missed.

The Ombudsman recommended that the Health Board apologise to Mr and Mrs Q for its poor communication and complaint handling and make a payment of £250 in recognition of these service failures. Further recommendations included sharing the Ombudsman's report with staff that cared for Mrs Q and updating the Ombudsman as to what action the Health Board was taking to improve waiting times in its EDs.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201903570 - Report issued in January 2021

Miss A complained about her pre-natal care and management at Betsi Cadwaladr University Health Board's ("the Health Board")Wrexham Maelor Hospital ("the Hospital") as well as her premature daughter, Baby R, being left unsupervised on her second day in the Hospital's Special Care Baby Unit ("SCBU"). Miss A was also dissatisfied with the Health Board's handling of her complaint and in particular, the robustness of its complaint response especially when it came to learning lessons.

The Ombudsman found that Miss A's prenatal management and care was broadly reasonable and appropriate, although administratively there were issues around record-keeping which meant it was not possible to determine the adequacy of communication with Miss A when she went into labour very early into her pregnancy. The Ombudsman concluded that the fact that it was not possible to reach a determination on her complaint represented an injustice to Miss A. As the Ombudsman determined that the shortcomings in record-keeping amounted to maladministration, to this extent only this part of Miss A's complaint was upheld.

In terms of the care provided to Baby R on the Hospital's SCBU, the Ombudsman concluded that the care provided was clinically appropriate and reasonable and the 1:2 nurse to baby ratio met Baby R's medical needs at the time. He therefore did not upheld this aspect of Miss A's complaint.

On complaint handling the Ombudsman identified that there were opportunities for reflective learning and improvements from Miss A's complaint, but the Health Board's process had been insufficiently robust to identify them. He considered the shortcomings in complaint handling caused Miss A an injustice as it had led her to question the robustness of the Health Board's complaint handling process and therefore the consideration given to her complaint. To this extent the Ombudsman upheld Miss A's complaint.

Formal recommendations that were made and accepted by the Health Board included apologising to Miss A for the failings identified and reminding medical clinicians about the importance of recording in the maternity notes sufficient detail of preterm labour "counselling" discussions with the patient, to demonstrate adequate and appropriate communication. Although they did not form part of the formal recommendations, as no failings in care had been found, the Health Board was also asked to consider, for example, training nurses in the SCBU around the care of catheter lines and introducing its own local policy and guidance on antenatal ultrasound scans.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 201906131 - Report issued in January 2021

Miss A complained about the care and treatment provided by Aneurin Bevan University Health Board to her late father, Mr B, in January 2019. Miss A complained that Mr B was inappropriately placed on a dementia ward (when he was admitted to hospital with pneumonia), about the nursing care Mr B received, and that there was a delay in identifying and appropriately treating sepsis. Miss A also complained about the Health Board's handling of her complaint.

The investigation found that Mr B was appropriately admitted to a ward overseen by 2 Consultant Respiratory Physicians. This element of the complaint was therefore **not upheld**. The Ombudsman found that nursing staff had failed to properly document care plans for Mr B or include his family in any care planning and, on 2 occasions, had failed to properly monitor Mr B on an hourly basis. The Ombudsman concluded that Mr B's deterioration might have been identified sooner had he been monitored appropriately and **upheld** this element of the complaint. The investigation found that, when sepsis was identified, the correct protocols were followed and Mr B received the appropriate care. However, given that Mr B was not monitored appropriately (as above), his deterioration might have been identified sooner and this element of the complaint was **upheld** to that extent. Finally, the Ombudsman found that the Health Board's complaint response included incorrect information and referred to treatment provided to Mr B a day after his sad death. This element of the complaint was also **upheld**.

The Health Board agreed to apologise to Miss A for the failings identified, remind clinicians to document clinical discussions, remind complaint handling staff of the importance of accuracy in complaint responses, and to share the Ombudsman's report with relevant staff.

The Health Board also agreed to provide refresher training to nursing staff on the use of early warning systems to identify acutely ill patients and sepsis and to ensure that staff of the relevant ward are up to date on such training.

A Practice in the area of Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 201906379 - Report issued in January 2021

Mrs A complained about the care and treatment that her late husband (Mr A) was afforded by the Practice, specifically in relation to his persistent urinary symptoms between July 2018 and May 2019. Mr A died in September 2019 following a cancer diagnosis.

The investigation found that investigations and referrals were not made in a timely manner. In addition, the respective GP's repeatedly prescribed Mr A with antibiotic treatment without reflecting on what the continuing urinary symptoms might have implied and did not concurrently put together a management plan. If an MSU had been undertaken at an earlier juncture (the earliest consultation whereby this was indicated was 11 December2018) it would have been evident that further investigations were required. An urgent referral should have been made under the suspected cancer pathway, if this had occurred then Mr A realistically would have seen by a specialist 12 weeks earlier (although it is possible that this would have been less). Whilst it is possible that an earlier cancer diagnosis may have meant the cancer would not have progressed to an incurable stage, it was impossible to definitively determine this issue. The investigation found that the uncertainty alone amounted to a substantial injustice to Mrs A.

The Practice agreed to provide a meaningful apology to Mrs A, disseminate the report to all GP's involved in Mr A's care for reflection and discussion with their appraiser and annual meeting and in addition, to undertake a significant event analysis.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201906799 - Report issued in January 2021

Mrs D complained that Betsi Cadwaladr University Health Board missed opportunities to diagnose and treat her husband's brainstem stroke at an earlier stage following his admission to Ysbyty Glan Clwyd on 29 July 2019. She was concerned that swifter action could have avoided the debilitating impact of the stroke on her husband.

The Ombudsman's investigation found shortcomings in the Health Board's assessment, investigation and diagnosis of Mr D's condition. As a result of these failings, the diagnosis of Mr D's stroke was delayed until it was too late for treatment options to be considered. Whilst the investigation was not able to determine whether treatment would have made a difference to Mr D's outcome, it found that the loss of the opportunity to have potential treatment options discussed was a significant injustice.

The Ombudsman recommended that the Health Board should within one month apologise to Mr and Mrs D and make a financial redress payment of £1,500. He also recommended that it should share the report with the Second and Third Doctors in the interests of improving their clinical practice. Finally, the Ombudsman recommended that the Health Board should develop an action plan to address the failings identified in the report within 3 months.

Powys County Council - Other
Case Number: 201907482 - Report issued in January 2021

Mr and Mrs A complained about how the Council progressed their application to seek a Special Guardianship Order ("SGO" – an order of the Family Court that can be made when a child is being cared for, more often than not, by people other than their parent until they reach the age of 18) for their foster child, B. Mr and Mrs A complained that the Council failed to progress matters relating to the SGO in a timely manner and in line with its statutory duty and failed to provide an appropriate and timely support package in line with its statutory duty.

Mr and Mrs A also complained about the way in which the Council dealt with their concerns. Specifically, that the Council failed to correspond with them in an appropriate and timely manner, failed to provide an apology for a data breach identified by the Information Commissioner's Office ("the ICO"), failed to conduct a comprehensive and thorough Stage 2 independent investigation, and failed to follow its complaint process in an appropriate and timely manner.

The investigation found that the lack of oversight, robust coordination and management decision making throughout the SGO application process caused prolonged and unreasonable delays. The frustration, anxiety and distress caused to Mr and Mrs A, and to B, by the delays, which were not in B's best interests, was an injustice to them.

The investigation found that the Council often failed to respond to or even acknowledge Mr and Mrs A's emails and failed to respond to their solicitor and fostering agency. The Council also failed to distribute Looked After Child review minutes in line with guidance, denying Mr and Mrs A an opportunity to request changes or raise concerns about them. The frustration, anxiety and distress caused to Mr and Mrs A, and the time taken to chase responses over a prolonged period was an injustice to them.

The investigation found that the Council failed to provide an apology for the data breach identified by the ICO. The data breach caused Mr and Mrs A and their family significant distress.

The investigation found that, overall, the Stage 2 investigation was thorough, had clear conclusions, correctly upheld several complaints, and made appropriate recommendations. However, there were several areas that could have been improved upon. The failure to conduct a sufficiently comprehensive and thorough Stage 2 investigation into all of their concerns caused Mr and Mrs A further frustration, and further compounded their distrust of the Council causing them a further injustice.

The investigation identified several failings by the Council in relation to its handling of Mr and Mrs A's concerns and also noted that their concerns were not dealt with in a timely manner. This compounded Mr and Mrs A's frustration, anxiety and distress. It also hampered the Stage 2 investigation due to the passage of time and the inability to interview key former staff. This was an injustice to them.

The Ombudsman upheld each of Mr and Mrs A's complaints.

The Council agreed to, within 1 month, provide a fulsome apology to Mr and Mrs A, including for the data breach, and make a payment of £1000 for the distress caused and the complaint handling failings identified. The Council also agreed to complete several steps to address the failures identified in its SGO, Stage 2 and complaints handling processes and to ensure robust data protection checks are undertaken.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201907550 - Report issued in January 2021

Mrs B complained about the care and treatment her husband, Mr B, received from Aneurin Bevan University Health Board. Specifically, Mrs B complained that the Health Board failed to refer Mr B to a pancreatic specialist pancreatic unit in a timely manner. Mrs B also complained that the Health Board failed to arrange a timely CT scan for Mr B. Finally, Mrs B complained that the Health Board failed to appropriately communicate with Mr B and his family regarding his condition.

The Ombudsman's investigation found no delay in the Health Board referring Mr B to the specialist pancreatic unit. Mr B was referred to the specialist pancreatic unit within an appropriate time frame and the Health Board carried out tests and investigations in a timely manner. As a result, the Ombudsman did **not uphold** this element of Mrs B's complaint.

With regard to the CT scan, the investigation found that appropriate procedures were conducted prior to undertaking the CT scan and there was no material impact on Mr B as a result. However, there was a 3 day delay in Mr B being reviewed following a procedure which resulted in his pain being poorly managed. The Ombudsman concluded that this was an injustice to Mr B and upheld this element of the complaint.

Additionally, the Ombudsman's investigation found that although the suspicions about the possibility of cancer were explained to Mr B and his family, the high degree of suspicion was not clearly communicated. He found that the communication with Mr B and his family about his diagnosis could have been more explicit. The Ombudsman concluded that this was an injustice to Mr B as it added to the shock he suffered when he was later informed he had cancer. As a result, the Ombudsman **upheld** this element of Mrs B's complaint.

The Health Board agreed to apologise to Mrs B for the failings identified in the report, to share the report with the clinicians involved in Mr B's care and confirm to the Ombudsman that the report had been used for critical reflection. The Health Board also agreed to remind relevant staff of the importance of clear communication with patients and families, particularly about the suspicion of cancer. Finally, the Health Board agreed to develop a clear pathway for patients undergoing the relevant procedures.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201901076 - Report issued in February 2021

Mrs E complained about Cardiff and Vale University Health Board's care and treatment of her mother, Mrs D, from 31 October 2017 up until her death on 15 February 2018. In particular, Mrs E was unhappy with her mother's interactions with the Health Board's Community Mental Health Team ("CMHT") and Response Enhanced Assessment Crisis Treatment ("REACT") team and questioned whether appropriate and timely care was provided. Mrs E was also unhappy with the Health Board's delay in responding to her complaint and the quality of its response.

The Ombudsman's investigation found that the care and treatment Mrs D received between 31 October 2017 and 15 February 2018 was timely and appropriate, and the level of interactions by the CMHT and REACT team with Mrs D and her family were sufficient. The Ombudsman did not uphold this part of the complaint.

The Ombudsman also found that whilst the communication between the two services was sufficient, it was recognised by the Health Board that it might have not been clear at all times to Mrs D and Mrs E and to address this it recommended that a protocol should be put in place when someone was accessing both services simultaneously. The Ombudsman was satisfied with the action taken by the Health Board. Finally, the Ombudsman found that the Health Board took almost a year to respond to Mrs E's complaint, far outside the stipulated timescales outlined in national guidance. The Ombudsman upheld this part of the complaint and recommended that the Health Board apologise to Mrs E and make a redress payment of £750 to reflect the distress caused by the delay.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201901233 - Report issued in February 2021

Mrs B complained about the care and treatment she received from Betsi Cadwaladr University Health Board ("the Health Board") in relation to her hyperparathyroidism (where the parathyroid glands, which are in the neck near the thyroid gland, produce too much parathyroid hormone). Mrs B said that the Health Board removed the incorrect parathyroid gland during surgery to treat her hyperparathyroidism.

Mrs B also complained that the Health Board's complaint response was not reasonable or accurate.

The Ombudsman's investigation found that the incorrect gland was removed during Mrs B's surgery on 19 June 2018. The ENT Surgeon should have reviewed Mrs B's scans himself and an additional ultrasound scan should have been undertaken. The ENT Surgeon should have recognised, during the surgery, that he was removing the incorrect gland. Mrs B's normal parathyroid gland was removed and as a result she continued to suffer symptoms and hyperparathyroidism. Accordingly, the Ombudsman upheld this element of Mrs B's complaint. The investigation also found that, while the Health Board investigated Mrs B's concerns and responded to her specific questions, its investigation failed to appropriately identify failings in Mrs B's care and failed to acknowledge her concerns. As a result, the Ombudsman upheld this element of Mrs B's complaint. The Ombudsman recommended that the Health Board should apologise to Mrs B for the failings and invite Mrs B to engage with an equivalent to the Putting Things Right Redress process. The Ombudsman also recommended that the Health Board should share the report with the clinicians involved in Mrs B's care for critical reflection, review its processes for pre-operative imaging and provide training to the relevant staff on the interpretation of pre-operative imaging.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201905232 - Report issued in February 2021

Dr A's complaint against the Health Board included the care and management he received from the Out of Hours GP Services ("OOH GP Services") and later in the Emergency Department ("ED"). Dr A also raised concerns about the OOH GP's record keeping as well as the Health Board's handling of his complaint. In relation to WAST, Dr A complained about the delay in his care being prioritised and the resultant delay in the ambulance being dispatched.

The Ombudsman's investigation concluded that care and management by the OOH GP was reasonable and appropriate and did not uphold this aspect of Dr A's complaint. In relation to the ED, the investigation identified that there was a delay in Dr A being reviewed by a doctor and the provision of pain medication and upheld this aspect of Dr A's complaint. In relation to Dr A's concerns about the delayed ambulance response, the Ombudsman concluded that operational and external difficulties had impacted on service provision. He was satisfied that failings and deviations in the call handling process, whilst amounting to a service failure, did not cause an injustice to Dr A and therefore did not uphold this aspect of Dr A's complaint.

In relation to the Health Board's handing of Dr A's complaint, the Ombudsman did not consider the delay to be excessive. However, he was of the view that administratively Dr A's complaint could have been handled better and it was to that extent that this aspect of Dr A's complaint was upheld.

Amongst the recommendations the Ombudsman made included the Health Board apologising to Dr A for the failings identified by the Ombudsman's investigation and putting in place measures to address delay and pain management in the ED.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201905261 - Report issued in February 2021

Mr A complained about the management of his wife's second stroke by Hywel Dda University Health Board's ("the Health Board") Withybush General Hospital in December 2018 during her inpatient admission. He felt that his wife's outcome would have been different had the concern he raised with the Night Nurse about his wife having another stroke been acted upon. He also questioned whether his wife's stroke might have been prevented if she had continued to take the anti-sickness medication which was changed in September 2018. Finally, he was dissatisfied with the Health Board's handling of his complaint including inconsistencies in its response when considered against the nursing records.

The Ombudsman's investigation found that, despite administrative and clinical failings, the evidence suggested that even if action had been taken sooner there would have been no significant difference in

Mrs A's stroke treatment. This was because clinical factors, such as Mrs A's stroke 3 weeks previously, meant she was not eligible for clot-busting treatment. In addition, Mrs A was already taking blood thinning medication. As Mrs A's outcome would not have changed and no injustice had therefore been caused, this part of Mr A's complaint was not uphold.

The Ombudsman was satisfied that stopping anti-sickness medication, including the type identified by Mr A, would not directly cause a stroke and therefore had no bearing on Mrs A's subsequent stroke. He also noted that Mrs A's blood pressure, although high, was relatively well controlled during her admission. The Ombudsman did not uphold this aspect of Mr A's complaint.

In terms of complaint handling, the Ombudsman considered that the Health Board could have been more robust in acknowledging shortcomings and opportunities for reflective learning around clinical record-keeping in its complaint response to Mr A. Given that this had caused Mr A to lose a degree of confidence and trust in the clinical records concerning his wife's care, the Ombudsman found that Mr A had been caused an injustice and to that limited extent only upheld this part of Mr A's complaint.

The Ombudsman recommended that the Health Board apologise to Mr A for shortcomings identified around complaint handling and that clinicians be reminded of the importance of record-keeping and documenting key conversations, clinical reviews and clinical changes.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905776 - Report issued in February 2021

Mr A complained about his late wife's care and management during her admission at Wrexham Maelor Hospital between 27 February and 4 April 2019. His concerns were of a delay in his wife's diagnosis/treatment of sepsis and poor kidney function, a lack of personal nursing care throughout Mrs A's admission, which included poor record keeping, and a failure to escalate her care to medical staff. Mr A complained about the lack of medical care given to his wife over the weekend of 30 March. Finally, he complained about poor communication regarding his wife's condition and the Health Board's complaint handling.

The Ombudsman found that whilst some aspects of the medical care Mrs A received were reasonable, he noted that there was a delay in Mrs A being diagnosed with sepsis on admission and its treatment with appropriate antibiotics. Whilst this was a service failure, the Ombudsman was satisfied that, even had Mrs A been started sooner on the sepsis medication, given her pre-existing medical condition, it would not have altered the ultimate outcome; consequently, this aspect of Mr A's complaint was not upheld.
In relation to nursing care the investigation highlighted that there were shortcomings in the nursing care provided to Mrs A, compounded by inadequate record keeping. The Ombudsman also found on several occasions there was a lack of engagement and poor communication with Mrs A's family about her care. The Ombudsman upheld this part of Mr A's complaint.

The investigation found that a failure to provide a robust complaint response meant that Mr A pursued his complaint further. This aspect of Mr A's complaint was upheld. The Ombudsman recommended that the Health Board apologise to Mr A and his family for the shortcomings highlighted, remind nursing staff of the importance of ensuring that nursing assessments are completed in line with local standards, and ensure that care planning is individualised to meet the needs of the patient, particularly the patient's preference when a family member assists with hygiene needs.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201906268 - Report issued in February 2021

Mrs T complained about the care provided to her late mother, Mrs M, by the Health Board during 3 admissions to hospital in May, June and July 2019. Mrs T said that there were failures to diagnose and treat Mrs M for sepsis, appropriately consider the concerns raised by Mrs M's GP and her family and ensure that Mrs M was well enough to be discharged in May and June. Mrs T also complained that the

Health Board failed to communicate sensitively with the family when Mrs M was coming to the end of her life.

The Ombudsman found that Mrs M's care and discharge in May were appropriate; there was no conclusive evidence that Mrs M had sepsis at that time. However, he found that Mrs M's discharge in June was inappropriate and that the Health Board failed to conduct appropriate sepsis screening and address Mrs M's symptoms of infection in June and July, despite both Mrs M's GP and her family raising concerns that she might have had sepsis. There were also occasions when Mrs M's deterioration was not reported to doctors appropriately. However, it was not possible to say whether Mrs M had sepsis in either June or July and Mrs M was treated with antibiotics by her GP in between her admissions. Therefore, the Ombudsman upheld these complaints, although he concluded it was unlikely that those shortcomings directly led to Mrs M's deterioration and ultimate outcome in July.

The Ombudsman also found that the Health Board failed to communicate sensitively and appropriately with Mrs M's family when they asked questions about her mother's care and in the hours before Mrs M died. However, the Health Board had already acknowledged this, apologised to the family and taken appropriate action to address it with the relevant clinicians. The Ombudsman did not consider it necessary to make any further recommendations, but he invited the Health Board to also ensure that the wider learning taken from this case also included consideration of the human rights of individual patients and their families and the impact on them if communication during a patient's final day or hours is undertaken poorly.

The Health Board agreed to share the Ombudsman's report with relevant staff and remind them of the importance of documenting and escalating early warning signs of deterioration as well as appropriate and safe discharge practices. It also agreed to review the sepsis training and competency of relevant staff members and take action to address any shortcomings. Finally, the Health Board agreed to apologise to Mrs T and offer her £1,000 as a token of recognition of the clinical failures identified.

Cwm Taf Morgannwg University Health Board & Swansea Bay University Health Board - Clinical treatment in hospital

Case Number: 201906835 & 201906837 - Report issued in February 2021

Mrs A complained about the care and treatment provided to her grandson, B, by the First and Second Health Boards. Specifically, she complained that the First Health Board gave her and B's father incorrect advice about B's eye conditions at an appointment in March 2017, which led to a delay in him being diagnosed with Optic Nerve Hypoplasia ("ONH" – the underdevelopment of the optic nerves) and photophobia (extreme sensitivity to light) until November 2019. Mrs A complained that the First Health Board failed to make them aware that it intended to review B again which meant that she did not chase further appointments when the letters the First Health Board said it had sent, were not received. Mrs A complained that the Second Health Board caused an unreasonable delay in undertaking an autism spectrum disorder ("ASD") assessment of B. Mrs A also complained that both Health Boards provided poor complaints handling by delaying their responses and not adequately addressing all her concerns.
The Ombudsman found that the lack of follow-up, and the delay in B's definitive ONH diagnosis, did not impact his visual development given that there was no treatment for B's eye conditions. The complaint was not upheld. The Ombudsman was unable to determine with certainty whether the appointment letters inviting B to follow-up appointments were posted but, for some reason, not received, or whether the letters (evidenced as created) were simply not posted by the First Health Board. As such, the Ombudsman was unable to make a finding in relation to this aspect of the complaint. The Ombudsman found that there was no delay in the First Health Board responding to Mrs A's concerns and the response provided appropriately answered her concerns. As such, this aspect of her complaint was not upheld. The Ombudsman did not uphold Mrs A's complaint that there was a delay in undertaking B's autism assessment. The Second Health Board experienced significant demand for its Neurodevelopment Service – an issue not only affecting the Second Health Board but across Wales and the UK. The Second Health Board offered Mrs A an apology and an ex-gratia payment of £250 in recognition of its poor complaint

handling. Mrs A accepted. This aspect of her complaint was settled and not investigated.

The events complained about occurred prior to changes in NHS provision in the Bridgend area. On 1 April 2019 NHS patient care for those living in the local government area of Bridgend was transferred from the former Abertawe Bro Morgannwg University Health Board to the former Cwm Taf University Health Board. At the same time, both were re-named Cwm Taf Morgannwg University Health Board ("the First Health Board") and Swansea Bay University Health Board ("the Second Health Board") respectively. Consequently, references to actions that occurred before 1 April 2019 are referred to as actions of the First Health Board.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201907102 - Report issued in February 2021

Ms X complained about the care and treatment she received from Cardiff and Vale University Health Board. The investigation considered her complaint that there was a delay in the Health Board diagnosing and treating her herniated disc and that it failed to explain the reason for the delay in diagnosing her herniated disc.

The Ombudsman found that whilst Ms X received timely reviews and the Orthopaedic Team were actively seeking to diagnose the cause of her pain, appropriate investigations were not undertaken and there was a delay in arranging a clinically appropriate MRI scan of Ms X's lumbar spine. This was a service failure as there was a delay in diagnosing and treating the cause of Ms X's pain for almost 2 years, causing an injustice to Ms X due to ongoing pain and distress and the need to seek private chiropractic treatment while waiting for diagnosis and treatment. This complaint was **upheld**.

The Ombudsman also found that the Health Board's complaint response, while detailed in outlining the various appointments, investigations and opinions requested in trying to obtain a diagnosis for Ms X's pain, failed to address her concern about a delay in diagnosing her herniated disk. This was maladministration and caused Ms X an injustice as her concern went unanswered. This complaint was **upheld**.

The Health Board agreed to apologise to Ms X for the identified failings and make a redress payment for the pain and distress caused by the delayed diagnosis and for the private chiropractic treatment she sought while waiting for a diagnosis and treatment. It also agreed to share the Ombudsman's report with the clinicians involved in Ms X's care and confirm to him that the report has been used for critical reflection and learning.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 201907230 - Report issued in February 2021

Mrs M complained about the care and treatment provided to her by Hywel Dda University Health Board ("the First Health Board") and Swansea Bay University Health Board ("the Second Health Board") concerning a displaced clavicle (a bone that serves a strut between the shoulder blade and breastbone). Mrs M said an unstable fracture of her clavicle was missed despite initial investigations and several hospital visits and she suffered pain and breathlessness for 3 months before it was identified. Mrs M also complained that the First Health Board did not provide her with updates on her complaint and delayed sending her complaint to the Second Health Board. Mrs M also complained that the Second Health Board did not communicate adequately with her about her condition and told her would be fit to travel in 6 weeks and reviewed in 6 months.

The Ombudsman found that the overall care and treatment provided to Mrs M by both Health Boards was satisfactory. However, the Ombudsman also found that the First Health Board did not fully inform the Second Health Board of the outcome of Mrs M's initial investigations, and the Second Health Board did not fully consider Mrs M's clinical context with regard to its radiology reports. As a result, opportunities to diagnose, monitor or treat Mrs M's condition promptly were lost, creating uncertainty for Mrs M as to

whether more could have been done at an earlier stage to help her. As such, these aspects of Mrs M's complaints were upheld to a limited extent. The Ombudsman also found the First Health Board had provided Mrs M with regular updates on her complaint, an explanation, and an apology about the delay in forwarding her complaint to the Second Health Board. This element of her complaint was not upheld. The Ombudsman found that the Second Health Board had provided appropriate travel advice to Mrs M. However, the Second Health Board acknowledged an error in communication about a follow up appointment which caused distress and anxiety for Mrs M. This aspect of her complaint was upheld to a limited extent.

Both Health Boards agreed (within 6 weeks of the final report) to apologise for the failings identified, and to share the final report with relevant clinical staff for critical reflection. The First Health Board also agreed to review the transfer of radiology images between sites. The Second Health Board also agreed to take steps to ensure clinical history is mentioned on radiological requests and reports, and that further investigations or specialist referral are suggested within the report when they contribute to patient management.

Hywel Dda University Health Board - Clinical treatment outside hospital
Case Number: 201907601- Report issued in February 2021

Ms X complained about the care and treatment provided by Hywel Dda University Health Board ("the Health Board") to her son, Y. Specifically, Ms X complained that the Health Board failed:

(a) To identify a knot in the umbilical cord prior to Y's birth.
(b) To appropriately monitor Y following his discharge from the Special Care Baby Unit.
(c) To prescribe appropriate antibiotics to Y.
(d) To arrange relevant scans in a timely manner.

The investigation found that it was very difficult to diagnose a knot in an umbilical cord prior to birth, and that Y was prescribed the correct preventative antibiotics at the correct dose when he was discharged from hospital. Therefore, complaints a) and c) were not upheld. In relation to complaint b), the investigation found that Y received an appropriate blood test on 10 January, that it was reasonable for that blood test not to be repeated before 20 February, and that Y appeared to be clinically well on 20 February, even though he was admitted to hospital with a urinary tract infection on 21February. The complaint was not upheld.

Complaint d) was upheld because Y should have received a specialists can more than 6 months before the scan was actually completed, which was partly due to Y being registered with 2 different surnames and 2 different hospital numbers. This delay caused considerable stress, and therefore injustice, to Ms X, although, thankfully, it did not cause any physical ill-effects to Y at the time.

The Health Board agreed to implement the Ombudsman's recommendations that it should apologise to Ms X and ensure that Y only had 1 hospital number and was registered with the correct surname within 2 months of the report. He also recommended that, within 6 months, the Health Board should undertake a review of its arrangements to ensure that when the relevant specialist scan is needed, the staff undertaking it have enough experience to make it likely there will be a successful outcome, whether this be through making formal arrangements with another Health Board or through offering training to its own staff. It should also confirm the outcome of the review to Ms X.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 202000466 - Report issued in February 2021

Mrs M complained about the care and treatment provided to her by Hywel Dda University Health Board ("the First Health Board") and Swansea Bay University Health Board ("the Second Health Board") concerning a displaced clavicle (a bone that serves a strut between the shoulder blade and breastbone). Mrs M said an unstable fracture of her clavicle was missed despite initial investigations and several

hospital visit sand she suffered pain and breathlessness for 3 months before it was identified. Mrs M also complained that the First Health Board did not provide her with updates on her complaint and delayed sending her complaint to the Second Health Board. Mrs M also complained that the Second Health Board did not communicate adequately with her about her condition and told her would be fit to travel in 6 weeks and reviewed in 6 months.

The Ombudsman found that the overall care and treatment provided to Mrs M by both Health Boards was satisfactory. However, the Ombudsman also found that the First Health Board did not fully inform the Second Health Board of the outcome of Mrs M's initial investigations, and the Second Health Board did not fully consider Mrs M's clinical context with regard to its radiology reports. As a result, opportunities to diagnose, monitor or treat Mrs M's condition promptly were lost, creating uncertainty for Mrs M as to whether more could have been done at an earlier stage to help her. As such, these aspects of Mrs M's complaints were upheld to a limited extent. The Ombudsman also found the First Health Board had provided Mrs M with regular updates on her complaint, an explanation, and an apology about the delay in forwarding her complaint to the Second Health Board. This element of her complaint was not upheld. The Ombudsman found that the Second Health Board had provided appropriate travel advice to Mrs M. However, the Second Health Board acknowledged an error in communication about a follow up appointment which caused distress and anxiety for Mrs M. This aspect of her complaint was upheld to a limited extent.

Both Health Boards agreed (within 6 weeks of the final report) to apologise for the failings identified, and to share the final report with relevant clinical staff for critical reflection. The First Health Board also agreed to review the transfer of radiology images between sites. The Second Health Board also agreed to take steps to ensure clinical history is mentioned on radiological requests and reports, and that further investigations or specialist referral are suggested within the report when they contribute to patient management.

Hywel Dda University Health Board - Clinical treatment outside hospital
Case Number: 202000482 - Report issued in February 2021

Mr X complained that, in February 2020, he was not assessed appropriately and reasonably by the Health Board, he was not offered appropriate care and treatment, and reasonable records were not created in relation to the involvement he had with the Health Board. Mr X also complained that the Health Board did not handle his complaint properly.

The investigation found that the Health Board did not undertake a detailed mental health assessment of Mr X, which limited its interaction with him to focusing solely on a single aspect of his presentation. This caused Mr X an injustice because he was denied the opportunity to explain and de-escalate his feelings, which may at least have led him to feel supported by the professionals involved in his care. This aspect of the complaint was therefore upheld. The investigation found that the decision to close Mr X's case was reasonable and therefore the complaint was not upheld, however the Health Board was invited to remind members of staff to communicate clearly to patients the outcome of assessments, even when this included closing referrals without accepting patients for services. The complaint that reasonable records were not created was not upheld. Although the complaint about the handling of Mr X's complaint was not upheld, the Health Board was invited to reflect on its process for complying with Subject Access Requests when the requestor had already made a complaint.

The Health Board agreed to fully and sincerely apologise to Mr X, and to review to what degree a first mental health screening should take place with a patient previously unknown to services, and to review the process of support and clinical supervision, particularly in decisions to involve outside agencies within 6 months.

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

hospital

Case Number: 202001536 - Report issued in February 2021

Mr P complained about the care and treatment provided to him by his GP Practice. In particular, he complained that the Practice failed to take appropriate action in relation to blood tests in May and October 2019 and that he had subsequently been diagnosed with blood cancer. He also complained about the way the Practice communicated with him in relation to his requests for medical information and in its approach to correspondence.

The investigation found that the assessments and decisions taken by the Practice in relation to Mr P's blood results fell within the bounds of acceptable clinical practice. This part of the complaint was **not upheld**. However, the investigation identified failings in the Practice's approach to communicating with Mr P. In particular, the Practice had not considered its obligations to Mr P under the Equality Act 2010 when responding to his request for communication by email. It had also failed to respond to a request for a copy of medical information and had failed to inform Mr P that he could submit complaint information electronically. This was an injustice because it caused Mr P avoidable stress and additional time and trouble at what was already a difficult time for him. The Ombudsman **upheld** this aspect of the complaint.

The Ombudsman recommended that the Practice should apologise to Mr P and make a payment to him of £250. He also recommended that the Practice should review its communication and complaint handling policy and that the Practice Manager should undertake appropriate training in the requirements of the Equality Act.

Swansea Bay University Health Board - Clinical treatment in hospital

Case Number: 202001697- Report issued in February 2021

Mrs B complained that Swansea Bay University Health Board ("the Health Board") failed to provide her daughter, Y, with appropriate care and treatment. In particular, Mrs B complained that when Y attended the Emergency Department ("ED") at Morriston Hospital, the Health Board failed to perform a scan which resulted in Y's condition deteriorating and a delay in Y receiving appropriate treatment.

The Ombudsman's investigation found that the assessment, examination and management of Y in the ED was appropriate. Appropriate tests and investigations were carried out in line with the relevant clinical guidance. The investigation found that it was within the bounds of acceptable clinical practice not to perform a scan and the delay in the diagnosis of Y's condition was not as a result of any clinical failing. However, the investigation found that Y's pain was not managed in accordance with the clinical guidelines and she was not offered pain relief. There was insufficient documentation to show that Y's pain score was appropriately assessed and monitored. This caused uncertainty and distress for Y and her family. Accordingly, the Ombudsman partly upheld Mrs B's complaint.

The Ombudsman recommended that the Health Board should apologise to Y and Mrs B for the failing identified. The Ombudsman also recommended that the Health Board should introduce a process in its ED's to ensure that assessment and documentation of pain at triage is achieved.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201902007- Report issued in March 2021

Mrs A complained on behalf of her adult son, Mr X, about his mental health treatment and care from the time of his initial GP referral in 2017 for symptoms of depression, anxiety and self-harm. In particular, Mrs A complained that Hywel Dda University Health Board failed to arrange for Mr X to be psychologically assessed and said that the overall assessment process was disjointed. She also complained about alack of access to secondary care services and therapeutic interventions on conclusion of the initial assessment process and the lack of Occupational Therapy ("OT") support during the admission to Canolfan Bro Cerwyn ("the Unit"). She said that the drug Aripiprazole was withdrawn on admission to the Unit and that there was a failure to arrange ongoing support and therapeutic interventions on discharge from the Unit.

Finally, Mrs A complained of a delay in Mr X receiving a series of assessments and reviews.

The investigation found that Mr X's access to secondary care services and therapeutic interventions on conclusion of the initial assessment process was reasonable, so this point was not upheld. However, although the Health Board's approach to assessment and to the withdrawal of Aripiprazole was reasonable, their communication with Mr X regarding both these aspects of his treatment was lacking. As a result, these elements of Mrs A's complaint were partially upheld. The Ombudsman recommended that the Health Board should apologise to Mr X for their poor communication within 1 month. He also recommended that the Health Board should remind all medical staff of the appropriate way to deal with patients' concerns within 2 months.

Mrs A's view that there was a lack of OT support during the admission to the Unit was upheld and her point that there was a failure to arrange ongoing support and therapeutic interventions on discharge from the Unit was partially upheld. This was because Mr X's needs were only partially met by OT support following his discharge from the Unit. The Ombudsman recommended that the Health Board's OT service should develop auditable assessment processes and that OTs should receive training/supervision within 6 months. Finally, Mrs A's point regarding delay in Mr X receiving a series of assessments and reviews was upheld and the Ombudsman recommended the Health Board should review Mr X's referrals within 2 months and their own referral processes within 6 months.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201903489 - Report issued in March 2021

Miss A complained about the care and treatment provided to her late mother, Mrs B, at Betsi Cadwaladr University Health Board's ("the Health Board") Deeside Community Hospital ("the Second Hospital") between 19 December 2017 and 16 February 2018, as well as the Health Board's handling of her complaint.

The Ombudsman's investigation found that Mrs B's management and care was reasonable and appropriate and that there was regular communication between clinicians and nurses and the family regarding their mother's palliative care needs. This part of Miss A's complaint was not upheld.
The Ombudsman was critical of the Health Board's complaint handling and concluded that a number of factual inaccuracies in the Health Board's complaint response, including the date that Mrs B had died, had undermined the family's confidence in the robustness of the complaint response. The Ombudsman found that the loss of confidence and added distress that these inaccuracies had caused, represented an injustice. He upheld this part of Miss A's complaint.

The Health Board agreed to the Ombudsman's recommendations that it apologise to Miss A and the family for the inaccuracies in its complaint response and that it ensure draft complaint responses are shared specifically with clinicians who have contributed to the response.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201905413 - Report issued in March 2021

Mrs F complained about the care and treatment her husband, Mr F, received from the Swansea Bay University Health Board ("the Health Board") while an inpatient in Singleton Hospital("the First Hospital") and Morriston Hospital ("the Second Hospital").

The Ombudsman's investigation found that at the point of Mr F's admission to the First Hospital, there was no indication that Mr F was suffering with an infection and there was no indication that he should have been given antibiotics. As soon as evidence of sepsis arose, antibiotics were correctly started and Mr F's sepsis was correctly and appropriately managed in line with relevant clinical practice. The Ombudsman's investigation identified that the management of Mr F's fluid balance was not appropriate while he was an inpatient in the First Hospital. However, it was found that, had the management of Mr F's fluid balance been appropriate, Mr F would still have sadly died. Accordingly, this element of Mrs F's

complaint was **not upheld**. However, the Ombudsman suggested that the Health Board reminds its staff of the importance of appropriate management of fluid balance for patients with diarrhoea.

With regard to Mrs F's complaint about the DNACPR, the investigation found that a formal DNACPR form was not completed for Mr F, which was not in line with relevant policy. However, while a formal form was not completed, the decision was clearly documented and communicated to Mr F's family who were informed that Mr F would not recover and that they should prepare for his possible imminent death. As aresult, the Ombudsman found that the failure to complete a DNACPR did not cause an injustice to Mrs F. Accordingly, this element of Mrs F's complaint was **not upheld**. However, the Ombudsman suggested that the Health Board reviews how it formally documents DNACPR orders for patients, to ensure it is in line with relevant policy.

Finally, the Ombudsman's investigation found that while there was evidence of some appropriate communication with Mr F and his family about his illness and treatment options, there was no evidence that his prognosis was discussed with him and his family. At the stage of Mr F's diagnosis, there was no documented discussion with him around his prognosis and there isno evidence that he was informed that treatment may not be curative. Further, while Mr F was an inpatient, there was no documented discussion in the clinical records of any communication between the clinicians and Mr F and his family, including at the stage it was recognised that Mr F was not responding to treatment and his prognosis was likely to be poor. Accordingly, this element of Mrs F's complaint was **partly upheld**.

The Ombudsman recommended that the Health Board should apologise to Mrs F for the shortcomings identified and offer her a payment of £500 to reflect the distress and uncertainty caused within 6 weeks of his report. The Ombudsman also recommended that, within 3months of his report, the Health Board should share the report with the relevant clinicians for critical reflection and learning and remind clinicians of the importance of ensuring adequate record keeping and documentation of communication with patients and their families, in particular when the patient is deteriorating.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201905416 - Report issued in March 2021

Mrs A complained about the care and treatment received by her late husband, Mr A, between 10 April and 15 April 2019. In particular, she complained that the Health Board prematurely discharged Mr A from hospital on 10 April and failed to adequately manage his discharge process, failed to give due consideration to his capacity to provide consent for abdominal surgery on 12 April and communicated poorly with the family, including in its handling of her complaint.

The investigation found that whilst it had been clinically appropriate to discharge Mr A from hospital, record keeping was poor and contravened the Health Board's Discharge Policy. This failing was an injustice to Mrs A as it caused her to doubt the appropriateness of her husband's discharge. This aspect of the complaint was upheld. The Ombudsman found no evidence to suggest that Mr A lacked the mental capacity to give his consent for surgery and did not uphold this part of the complaint. The investigation found failings in the standard of communications with the family, both while Mr A was in hospital and in the handling of Mrs A's complaint. The opportunity was missed to address Mrs A's concerns sooner, which caused her avoidable distress and is an injustice. This part of the complaint was upheld.

The Ombudsman recommended that within 1 month of the report, the Health Board apologise to Mrs A and make a redress payment of £250 in recognition of the avoidable time and trouble of escalating her complaint and to share the report with clinicians for critical reflection and learning. The Ombudsman recommended that within 6 months, the Health Board should review the mechanisms in place to ensure the standard and consistency of surgical record keeping, including where procedures are carried out by locum consultants.

Betsi Cadwaladr University Health Board - Other

Case Number: 201906009 - Report issued in March 2021

Mrs B complained that the terms of a Lasting Power of Attorney for Health and Welfare ("an LPA") which she held in respect of her (late) friend and donor, Mr P, were disregarded by a District Nurse ("a DN") employed by the Health Board and by a GP Practice in the area of the Health Board. Mrs B complained that a GP Practice Nurse administered a flu vaccination injection to Mr P and that the DN prescribed antibiotics to Mr P for a possible urinary tract infection without consulting with her and without regard for his preference to receive homeopathic treatments for ailments in the first instance.

Mrs B also complained that her complaint correspondence and other communications with the GP Practice were poorly managed and were not responded to in accordance with the NHS complaint procedure and/or good administrative practice.

The Ombudsman partially upheld Mrs B's complaint against the DN, finding that, although she acted in accordance with clinical guidance and in Mr P's best interests, her attempts to consult with Mrs B were only partially successful and were not followed up. He also partially upheld Mrs B's complaint against the GP Practice as, although its reasons for not consulting with Mrs B were reasonable, it failed to adequately record how consent for the vaccination was obtained from Mr P. The Ombudsman did not consider that Mr P's preference for homeopathic remedies was disregarded as this option was not requested by Mr P or advanced by Mrs B in her discussions with the DN. The Ombudsman upheld Mrs B's complaint about the GP Practice's poor standards of communication and its complaint handling.

The Ombudsman recommended that the Health Board and the GP Practice should apologise to Mrs B for the identified failings and that the GP Practice should make a payment of £250 to Mrs B in recognition of its poor complaint handling. The Ombudsman also recommended:

- That the Practice Manager and GPs undergo revision and review of the provisions of PTR, and that the Practice develops a policy to be used where complaints are considered vexatious/persistent.
- That Practice staff are reminded of the importance of clear, detailed and accurate record-keeping and the requirement to record details of patient consent.
- That the Practice Manager and GPs undergo revision of the principles of the legislation governing LPAs and the role of attorneys in patient care.

Both the Health Board and the Practice agreed to implement these recommendations.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201906102 - Report issued in March 2021

Mrs K complained about the overall care and treatment she received at Nevill Hall Hospital between June and December 2018. In particular, she was unhappy at waking during her first endoscopic retrograde cholangiopancreatography ("ERCP") procedure and having to be physically restrained, following the removal of her gallbladder she was discharged too soon after the operation and had to return to hospital only a few days later, during a further hospital stay she contracted E-Coli which she said was caused by poor hygiene and a second ERCP procedure, and being administered an antibiotic, closely related to penicillin, that made her vomit despite being given allergy bracelets.

The Ombudsman's investigation found that the first ERCP procedure Mrs K had was carried out by an appropriate surgeon to a high standard: Mrs K was appropriately consented and was aware the procedure would be undertaken while she was consciously sedated. Whilst it was not a success, Mrs K's subsequent pancreatitis was a known risk of the procedure. The Ombudsman also found that the E-Coli that Mrs K contracted after the second ERCP was a direct complication of the procedure and a recognised risk. The Ombudsman did not uphold these parts of the complaint.

However, the Ombudsman did conclude that following the removal of Mrs K's gallbladder, she was discharged too soon after the operation without a proper plan in place to monitor the possible issue of

fluid and electrolyte imbalance. He also found that following the insertion of a t-tube to drain excess bile, the drainage levels were not monitored correctly, and Mrs K was discharged when her levels were still too high. The Ombudsman also concluded that Mrs K was incorrectly administered an antibiotic, closely related to penicillin, that made her sick despite staff being aware of her penicillin allergy. The Ombudsman upheld these parts of the complaint.

During his investigation the Ombudsman was concerned to note that prior to Mrs K's first ERCP, a scan showed a possible stricture that was not identified until much later. Whilst the Ombudsman could not be certain as to what course of action would have been taken if the stricture had been identified sooner, it was clear that it would have been integral to Mrs K's management plan thereafter, and there was some uncertainty as to whether some of the problems she faced might have been avoided. The Ombudsman concluded that this was a service failure.

The Ombudsman recommended that Mrs K receive an apology and a redress payment of £1,000. He also recommended that the report was shared with the staff involved in Mrs K's care, including radiology, surgical and gastroenterologist consultants, to identify improvements, and that a patient information leaflet was created about going home with a t-tube. Aneurin Bevan University Health Board agreed to the Ombudsman's recommendations.

Aneurin Bevan University Health Board - Health
Case Number: 201906226 - Report issued in March 2021

Mrs A complained that Aneurin Bevan University Health Board failed to communicate adequately with her regarding the seriousness of her mother's ("Mrs B") condition and that this resulted in Mrs A being away when her mother died, that it failed to drain fluid from her mother's abdomen in a timely manner and that this failure contributed to her mother's death, that it failed to review her mother's Do Not Attempt Cardiopulmonary Resuscitation order ("DNAR") within an appropriate timeframe and that its handling of her complaint was poor.

The investigation found that Mrs B's deterioration had been more rapid than expected and that whilst the seriousness of her condition was explained to the family during her final admission, more could have been done to make them aware of her potential for deterioration the first time she was admitted. This aspect of the complaint was upheld to that extent. The Investigation also found that the decision not to drain Mrs B's stomach did not contribute to her death but that the failure to send a sample for testing was an omission in care. This part of the complaint was therefore upheld to that limited extent. The Ombudsman upheld Mrs A's complaint that the DNAR was not reviewed within an appropriate timeframe and that its handling of Mrs A's complaint was poor.

The Ombudsman recommended that the Health Board should provide Mrs A with a written apology and make a redress payment of £250 in recognition of the time, trouble and distress she incurred in pursuing her complaint. He also recommended that the Health Board should share the report with staff, reflect on the failings, review its processes accordingly including the DNAR process, out of hours cover by gastroenterology staff and implement consistent management of patients with decompensated liver cirrhosis.

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 201906411- Report issued in March 2021

Mr and Mrs A complained about the poor care and management of their invitro fertilisation ("IVF") treatment by Swansea Bay University Health Board's Welsh Fertility Institute. Their concerns included not being given accurate timelines and information about their care and management, as well as a failure to inform Mrs A about her endometriosis. Administrative shortcomings in the "witnessing documentation" of the sperm samples Mr A had provided in 2009 had led to them being refused treatment by another provider. Finally, they also complained about the Health Board's complaint handling including poor communication and inaccurate responses.

The Ombudsman's investigation concluded that the Health Board had provided an accurate timeline of Mr and Mrs A's care and that there was no evidence that Mrs A had endometriosis; these aspects of their complaint were not upheld. The investigation found that the administrative failings around the "witnessing documentation" for Mr A's sperm sample and the Health Board's subsequent complaint handling caused them additional distress. These aspects of their complaint were upheld.

The Ombudsman was pleased to note that the Health Board had readily accepted its shortcomings and offered appropriate financial redress, as well as putting measures in place to ensure that such shortcomings did not re-occur. The Health Board was asked to apologise to Mr and Mrs A and pay them the sum of £1000 in recognition of the distress caused as a result of the shortcomings identified by the investigation.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201906785 - Report issued in March 2021

Mr B complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to provide him with appropriate treatment between October 2018 and June 2019, which led him to pay privately for treatment, including a consultation and private operation.

The Ombudsman's investigation found that there was a delay in referring Mr B for an outpatient review by a Consultant Urologist. This resulted in Mr B having to wait longer to be seen, which was an injustice to him. The investigation also found that following Mr B's referral, which was marked as urgent requiring an outpatient appointment within 6 weeks, Mr B was not seen within that timeframe and received no communication from the Health Board. Mr B should have been seen urgently and the Health Board's delay without any communication from the Health Board was a service failure. As a result of the lack of communication from the Health Board, it was understandable that Mr B sought a private consultation to establish the cause of his condition and to find out how it could be corrected. Accordingly, this element of Mr B's complaint was upheld.

The Ombudsman's investigation found that there was no evidence of a service failure in respect of how long Mr B would have waited for the operation. Mr B's condition was benign and not life th reatening, and therefore it would have been reasonable to expect him to wait for a routine operation and it was acceptable practice for the Health Board to prioritise more urgent conditions. Mr B chose to have private care and did not inform the Health Board of his intention, in order to give it an opportunity to add him to the NHS list for the operation or tell him how long that wait might be.

The Ombudsman recommended that the Health Board should apologise and provide a redress payment of £500 to Mr B for the failures identified in the report. He also recommended that the Health Board should provide Mr B with the £186 cost incurred for the private consultation. Finally, the Ombudsman recommended that the Health Board should share the report with the relevant clinicians for critical reflection and review how it communicates with patients waiting for outpatient review.

A GP Practice in the area of Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 201907391 - Report issued in March 2021

Mrs B complained that the terms of a Lasting Power of Attorney for Health and Welfare ("an LPA") which she held in respect of her (late) friend and donor, Mr P, were disregarded by a District Nurse ("a DN") employed by the Health Board and by a GP Practice in the area of the Health Board. Mrs B complained that a GP Practice Nurse administered a flu vaccination injection to Mr P and that the DN prescribed antibiotics to Mr P for a possible urinary tract infection without consulting with her and without regard for his preference to receive homeopathic treatments for ailments in the first instance.

Mrs B also complained that her complaint correspondence and other communications with the GP Practice were poorly managed and were not responded to in accordance with the NHS complaint procedure and/or

good administrative practice.

The Ombudsman partially upheld Mrs B's complaint against the DN, finding that, although she acted in accordance with clinical guidance and in Mr P's best interests, her attempts to consult with Mrs B were only partially successful and were not followed up. He also partially upheld Mrs B's complaint against the GP Practice as, although its reasons for not consulting with Mrs B were reasonable, it failed to adequately record how consent for the vaccination was obtained from Mr P. The Ombudsman did not consider that Mr P's preference for homeopathic remedies was disregarded as this option was not requested by Mr P or advanced by Mrs B in her discussions with the DN. The Ombudsman upheld Mrs B's complaint about the GP Practice's poor standards of communication and its complaint handling.

The Ombudsman recommended that the Health Board and the GP Practice should apologise to Mrs B for the identified failings and that the GP Practice should make a payment of £250 to Mrs B in recognition of its poor complaint handling. The Ombudsman also recommended:

- That the Practice Manager and GPs undergo revision and review of the provisions of PTR, and that the Practice develops a policy to be used where complaints are considered vexatious/persistent.
- That Practice staff are reminded of the importance of clear, detailed and accurate record-keeping and the requirement to record details of patient consent.
- That the Practice Manager and GPs undergo revision of the principles of the legislation governing LPAs and the role of attorneys in patient care.

Both the Health Board and the Practice agreed to implement these recommendations.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202000315 - Report issued in March 2021

Mrs D complained about the care and treatment that her mother, Mrs M, received at Ysbyty Glan Clwyd's Emergency Department ("ED") following her admission with a suspected ischaemic stroke. Mrs D complained that clinicians failed to administer thrombolysis (blood-clot dissolving medication) to Mrs M within a timeframe of 4.5 hours (as stipulated in clinical guidance), with the result that she suffered severe physical and cognitive deterioration.

Mrs D also complained that, having been assured that an investigation of this incident would be conducted by the Health Board (and shared with the family), she discovered, after several months, that, before this could happen, she was required to submit a formal written complaint. This was not explained to her at the time and resulted in delay in her receiving the Health Board's complaint response.
The Ombudsman upheld Mrs D's complaint that an ED (middle-grade) doctor failed to review a radiology report (which confirmed an ischaemic stroke) in time to administer thrombolysis within the 4.5 hour timeframe. He found that the ED doctor was unaware of the stroke-care protocol and failed to act with the urgency required by Mrs M's condition. However, the Ombudsman could not conclude that Mrs M suffered any adverse clinical consequences as a result of this failing due to the modest statistical likelihood of the thrombolysis treatment improving Mrs M's condition. The Ombudsman nevertheless considered that the loss of this opportunity was an injustice to Mrs M. He also found that whilst it could not be determined that the physical and cognitive deterioration that Mrs M suffered could have been avoided or made less acute by receiving the thrombolysis, the uncertainty of this matter was a source of distress to the family and, as such, an injustice.

The Ombudsman upheld Mrs D's complaint about poor complaint handling.

The Ombudsman recommended that the family be provided with a fulsome and meaningful apology for the clinical and complaint-handling failings identified and that the Health Board makes a payment of £500 to Mrs D in recognition of the enduring distress to the family and a further £250 in recognition of the complaint handling failings.

He also recommended that the Health Board:

- Confirms that the ED doctor receives additional training/support in stroke care and provides, in due course, evidence of reflection on this incident within his annual appraisal
- Confirms that guidance issued to junior ED doctors is reviewed and updated so that the processes for administering stroke thrombolysis are more clearly and explicitly defined
- Considers incorporating into the guidance additional information suggested by one of the Ombudsman's Advisers
- Provides the Ombudsman with evidence of ED-wide training in stroke-care
- Shares this report with the Concerns Team so that the identified failings in complaint handling in this case can be reflected upon.
- Finally, the Ombudsman invited the Health Board to share the outcome of an ongoing review of the way in which Serious Incident Reviews are shared with/communicated to patients and families.

The Health Board agreed to implement these recommendations.

A GP Practice in the area of Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 202001804 - Report issued in March 2021

Mr and Mrs X complained that when Mrs X (who had a history of chronic obstructive pulmonary disease, "COPD" - a lung condition causing breathing difficulties) attended a consultation with a GP ("the GP") at a GP Practice in the area of Swansea Bay University Health Board ("the Practice") on 28 January 2020 with shortness of breath and difficulty breathing, the prescription of Ventolin (a medication that opens up the airways in the lungs and is also known as salbutamol) was inappropriate. Mr and Mrs X said that the change to Mrs X's medication caused Mrs X's physical deterioration resulting in her hospital admission some days later (and a diagnosis of atrial fibrillation – "AF"). They believed that the prescription caused heart problems and said that Mrs X must now take regular heart medication.

The Ombudsman found that the prescription of Ventolin was appropriate based on Mrs X's symptoms and was in line with relevant national guidelines. However these guidelines were not followed once the decision to prescribe Ventolin was made, as the GP did not provide advice or support as required. The Ombudsman upheld this complaint. However, as the GP and Practice had identified and addressed this shortcoming through the Practice's investigation of Mr and Mrs X's complaint and had taken action to learn from this event, the Ombudsman decided not to make a formal recommendation as a result. He did ask the GP / Practice to reflect on this issue and the learning points that it had already identified.

The Ombudsman concluded that, whilst the prescription of Ventolin may have possibly contributed to Mrs X's AF, it did not cause it. The exacerbation of her COPD before her hospital admission was, on balance, more likely to have contributed to her AF. This complaint was not upheld.

Hywel Dda University Health Board - Clinical treatment in hospital
Case Number: 202003187 - Report issued in March 2021

Mrs X complained that Hywel Dda University Health Board ("the Health Board") failed to identify that she had a subluxation, a partial dislocation, of her thumb and failed to provide appropriate care and treatment for the subluxation.

The Ombudsman found there was no definitive evidence of a subluxation of Mrs X's thumb. This aspect of the complaint was not upheld. Given there was no definitive evidence of a subluxation of Mrs X's thumb the Ombudsman considered whether the care and treatment provided to her was appropriate in the circumstances. The Ombudsman found that, overall, the care and treatment provided to Mrs X was appropriate. However, the investigation found there was a delay in arranging an MRI scan and a delay inbeing seen by a hand specialist in another Health Board despite her acute injury. Further, the matter was not discussed at a multi-disciplinary meeting. Had it done so; a definitive diagnosis could have been

reached sooner. Consequently, Mrs X was immobilised in a plaster cast for an unnecessarily long period resulting in her being unable to drive and losing her independence, and caused emotional distress and stiffness, which was an injustice to her. Therefore, this aspect of the complaint was upheld.

The Health Board agreed to apologise to Mrs X and pay her £500 in recognition of being immobilised for an unnecessarily long period. It also agreed to share the Ombudsman's report with the with relevant staff for reflection and learning to improve their future performance and review the pathway for referring acute hand injuries to another Health Board to prevent any future unnecessary referral delays.

Not Upheld

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201905846 - Report issued in January 2021

Mrs X complained about her treatment when pregnant at Wrexham Maelor Hospital between 5 January 2018 and 31 May. On 22 May at 23:10, Mrs X presented with mild vaginal bleeding and she was reviewed on 23 May at 00:10, a cardiotocography (means of recording fetal heartbeat and uterine contractions) was noted as normal. A request for an urgent ultrasound scan was declined and clarification sought as Mrs X was listed for USS on 30 May. Mrs X's 30 May USS reported the baby's demise. On 31 May Mrs X's daughter was delivered by caesarean section, sadly, as a stillbirth. Mrs X also complained about her thyroid management and that she was portrayed as a heavy smoker.

The Ombudsman found that even had a USS scan been performed on23 May it would not have led to a different outcome. He also found that Mrs X's thyroid management was appropriate as the baby's growth velocity was maintained throughout her pregnancy until 30 May, which sadly reinforced that the demise was because of placental abruption and not placental function. Mrs X smoked throughout her pregnancy. The Ombudsman found that Mrs X's treatment between 5 January 2018 and31 May was to an acceptable clinical standard. The complaint was not upheld. The Ombudsman invited the Health Board to consider a robust policy/guide to improve counselling and education about the hazards for women who continue to smoke during pregnancy.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202000197 - Report issued in January 2021

Mrs B complained about the care and treatment provided by Aneurin Bevan University Health Board ("the Health Board") during the birth of her daughter, Baby Y.

The Ombudsman's investigation found that the care and guidance given to Mrs B during the second stage of her labour was both individualised and appropriate. The decision to attempt vaginal delivery of the baby was also appropriate as there was a diagnosis of delay in the second stage of Mrs B's labour and intervention was indicated. The investigation also found that there was no evidence of any inappropriate force used during Baby Y's delivery. As a result, the Ombudsman did not uphold Mrs B's complaint.

Cardiff and Vale University Health Board - Clinical treatment outside hospital
Case Number: 201900893 - Report issued in February 2021

Miss A complained on behalf of her mother, Mrs B, that multiple cuts caused to her toes during podiatry treatment became infected and developed gangrene, resulting in the amputation of her lower right leg. Miss A also complained that, following Mrs B's admission to hospital, Cardiff and Vale University Health Board ("the Health Board") failed to provide appropriate and timely treatment of the infection and gangrene in her toes.

The investigation found that Mrs B's right big toe was accidentally cut on one occasion during podiatry treatment. The treatment was found to be necessary and appropriate, and although not ideal, accidental cuts were not uncommon due to the sharp instruments used. There was no evidence to support that this

cut became infected, or that multiple accidental cuts were caused to Mrs B's toes. However, there was evidence that Mrs B had worsening peripheral arterial disease which first presented as ulceration, then infection and gangrene to the middle toe of her right foot resulting in her admission to hospital. The investigation also found that the incremental approach taken by the Health Board to Mrs B's hospital treatment was appropriate to her clinical need, and in accordance with national guidelines on the management of patients with peripheral arterial disease. Sadly, although every effort was made to try and save Mrs B's lower leg, the severity of her disease meant there was very little chance of successful intervention to prevent the amputation.

The Ombudsman did not uphold Miss A's complaints.

Case Number: 201906316 - Report issued in February 2021
Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Mr A complained about the care and treatment he received from Betsi Cadwaladr University Health Board between March and April 2019. He complained that an operation to remove his appendix was unnecessary and that the surgery was not carried out to an acceptable standard as two further surgeries were required to deal with bleeding at the appendix site.

The investigation found that the decision to remove Mr A's appendix was clinically reasonable and was made in his best interests, according to the information that was available at the time, and that there was no evidence that the surgery to remove his appendix was carried out to an unacceptable standard. The complaint was **not upheld**.

A GP Practice in the area of Cardiff & Vale University Health Board - Clinical treatment outside hospital
Case Number: 201906718 - Report issued in February 2021
Mr E complained about a delay/failure of a GP Practice in the area of Cardiff and Vale University Health Board ("the Practice") in investigating her late mother, Mrs T's, throat and neck problems between May **2018** and May **2019**. Mrs T moved to live with Mrs E in England in July and, following investigations there, was diagnosed with lymphoma (a type of blood cancer) very soon afterwards. Mrs T sadly died in July **2020**.

The Ombudsman found that none of Mrs T's consultations with the Practice before May 2019 related to her neck problem, and a private ENT referral was made in May when Mrs T complained of catarrhal symptoms. The Practice was reassured by the fact that the ENT Surgeon's investigations did not reveal any indication of serious illness. The doctor who saw Mrs T at the end of July was concerned she was deteriorating, and made an urgent referral to the neck clinic. The Ombudsman concluded that the Practice had acted appropriately and promptly and there was nothing further which should have been done. He **did not uphold** the complaint.

Cwm Taf Morgannwg University Health Board - Clinical treatment in hospital
Case Number: 201906720 - Report issued in February 2021
Mrs X complained about her treatment between 21 and 24 August 2018. Mrs X was dissatisfied that she had not had a scan when she was admitted for induction of labour, that when she was given birth options she could not make an informed decision, that her baby was only placed skin to skin for a very short time and that a named midwife should have supported her throughout the induction process.

The Ombudsman found that after a scan shortly before her admission to hospital, in view of Mrs X's assessments and examinations, it was reasonable that another scan was not considered. He found that no opportunities were missed during Mrs X's induction of labour period to have detected her baby's breech presentation. He found that when Mrs X was given the birth options she was keen for a vaginal delivery. As her labour progressed so quickly, there was no other opportunity to have discussed the birth options. The Ombudsman also found that although the baby was placed briefly on Mrs X's stomach atop clothing, this was necessary in view of her and the baby's care, which was reasonable. Finally, the Ombudsman

found that the induction process can take longer than the midwife's shift and it would not be reasonable to have a named midwife for the whole procedure. The complaint was therefore not upheld.

A GP Practice in the area of Hywel Dda University Health Board - Clinical treatment outside hospital
Case Number: 201902393 - Report issued in March 2021

Mrs B complained that the Practice inappropriately delayed referring her husband, Mr C, to a gastroenterologist for further investigations in view of his history of Barrett's Oesophagus (a condition where the normal cells lining the gullet are replaced with abnormal cells and can develop into oesophageal cancer in a small number of people), and presentation with worsening symptoms of dyspepsia (upper abdominal pain or discomfort). Mr C developed problems with his swallow in November 2017 and was later diagnosed with oesophageal cancer.

Mr C had a long history of gastro-oesophageal reflux disease("GORD" - where the ring of muscle at the bottom of the oesophagus weakens enabling stomach acid to pass back up the oesophagus causing dyspepsia). The Ombudsman found that Mr C's presentation with worsening symptoms of dyspepsia in February2017 coincided with a change in his drug therapy for GORD. His medication was changed on pharmacological advice, but Mr C reported that it was less effective at controlling his symptoms. The evidence supported the main objective of each consultation after that time which was to find the best drug therapy to control Mr C's dyspepsia. There was no evidence that Mr C reported any other symptoms that might have prompted further consideration of a referral before November 2017, and an urgent referral was then made a week later.

The Ombudsman found that, on balance, Mr C's treatment and care fell within a range of appropriate practice based on the information available at that time, and without the application of hindsight given his later diagnosis. The complaint was not upheld.

A Practice in the area of Cwm Taf Morgannwg University Health Board - Clinical treatment outside hospital
Case Number: 201905387- Report issued in March 2021

Ms X was diagnosed with Emotionally Unstable Personality Disorder ("EUPD") and undergoing Dialectical Behaviour Therapy ("DBT" - treatment of personality disorder). On 6 August 2019 at the Royal Gwent Hospital Ms X complained that, for 7 years she suffered severe reflux symptoms (when stomach acid travels up towards the throat) and weight loss. The symptoms started when she started on sertraline (anti-depressant), and she wanted to come off this drug. It was agreed to decrease the medication by 50 mgs a week until stopped and a letter was written to Ms X's GP requesting this. On 7 August Ms X's sertraline was reduced to every few days. On 16 August Ms X attended the Practice her ongoing reflux was discussed and it was noted that she had stopped taking sertraline. On 21 August Ms X was admitted to the Hospital having self-harmed and with thoughts of harming others, it was noted she had significant deterioration in her mental health triggered by seeing an alleged abuser, she had recently started DBT, the children were on school holidays, sertraline was discontinued rapidly and she had a new care co-ordinator. Ms X's Advocate complained that the Practice failed to appropriately manage her reduced doses of anti-depressants and this failure resulted in her emergency admission to a local Mental Health Unit.

The Investigation found that self-harm and thoughts of harming others are not common withdrawal effects from sertraline cessation. While it was a service failure by the Practice in its prescription instruction, the prescribing error was not identified as the main or only stressor at admission, but in view of other stressors noted, the sertraline withdrawal could not be associated with her admission. The complaint was not upheld.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 201907473 - Report issued in March 2021

Ms A complained about the care and treatment that she received when she attended the Emergency Department ("ED") at the University Hospital of Wales ("the Hospital") on 8 December **2018**. Specifically, Ms A questioned whether the Advanced Nurse Practitioner ("ANP") was the appropriate clinician to have

undertaken the clinical assessment and make a clinical diagnosis. Whether, given her reported and observed symptoms, the assessments and examinations undertaken by the ANP were clinically appropriate, and whether the clinical notes were sufficiently detailed. Whether appropriate consideration was given to her previous hip/spinal problems and the factors that would place her at higher risk of bone fracture. Whether, given her reported and observed symptoms, the appropriate clinical investigations were requested and undertaken. In addition, whether the investigative X-rays were reported on correctly by the Consultant Radiologist. Whether the pain relief medication prescribed, and the advice provided by the ANP upon discharge, were both clinically appropriate. Whether a walking aid should have been provided, and/or any onward referrals or follow up appointments made upon discharge from the ED.

The investigation found that the ANP had received the required training and experience to allow her to undertake the clinical assessment and diagnosis. In addition, it found that the assessment and examinations undertaken were clinically appropriate and the notes of the ANP were sufficiently detailed. The investigation found that the X-rays were reported on to an appropriate clinical standard however a better form of words could have been entered on the X-ray report. No formal recommendations could be made as this aspect of the complaint was not upheld however the Health Board were invited to consider the clinical advisers comments in relation to this matter.

The investigation found that the clinical records did not outline any of the risk factors (save for Ms A's age) as listed within the Osteoporosis: assessing the risk of fragility fractures" [CG146] ("the NICE Guidance"). Ms A disputed this and considered that she did have a number of risk factors and therefore a fragility risk assessment should have been undertaken. The clinical advice was that even if a risk assessment had been indicated and undertaken, the discharge plan would not have altered.

The investigation found that it was appropriate for Ms A to have been discharged on 8 December with pain relief and advice to mobilise. She could have been advised to return to a clinical setting if there had been no improvement within1 to 2 weeks or if her symptoms became worse. The clinical records did not evidence that this advice was given however the failure to provide it, did not itself amount to inappropriate clinical practice. The Health Board have reminded clinical staff of the importance of safety netting advice in the discharge process which was pleasing. As this aspect of the complaint was not upheld, no formal recommendations could be made however the Health Board were invited to provide a copy of the report to the ANP (who had left the Health Board) to highlight the importance of both safety netting advice and documenting the discussion with the patient.

The investigation found that as Ms A was walking unaided (albeit with difficulty) around ED, an onward referral to physiotherapy was not warranted and this would have been the avenue by which a walking aid would have been provided.

For the reasons outlined above, Ms A's complaint was not upheld.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202002603 - Report issued in March 2021

Ms L complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to offer her father, Mr D, an appointment with a Cardiologist within a reasonable timeframe following the identification of Mr D's new heart murmur in March 2019. She also complained that the Health Board failed to investigate and treat Mr D's condition promptly, appropriately and in line with relevant guidance, and that it failed to communicate appropriately with Mr D about his condition and management plan.

The Ombudsman found that Mr D's referral to the hospital was inappropriately downgraded from urgent to routine but that the delay in offering him an appointment with a Consultant did not result in any clinical impact because Mr D did not have a significant heart condition at that point. He found that the cause of Mr D's heart murmur was already being appropriately treated with medication and that the Consultant's assessment and treatment plan was in line with relevant guidance. He also found that Mr D had been

informed of his test results and the outcome of the Consultant's assessment appropriately. However, he considered that it would have been helpful if Mr D had been informed that his initial referral had been downgraded from urgent to routine.

The Ombudsman did not uphold Ms L's complaint, but he invited the Health Board to consider drawing up relevant and consistent criteria that clarify and define when a referral should be progressed as urgent. He also invited the Health Board to consider introducing a policy which requires correspondence to be copied to both the GP and the patient involved, to ensure that all parties are fully informed. The Health Board confirmed that it would take these suggestions forward.

Early Resolution or Voluntary Settlement

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 202003524 - Report issued in January 2021

Mrs X complained about the maternity care and treatment she received from the Health Board. Mrs X complained about placental products left following the birth of her child and considered this led to a continuing infection, postpartum haemorrhage and emergency surgery 6 weeks later. Mrs X was unhappy that she was not informed of possible retained products or offered advice about risk of retained placenta and said that she should have been made aware of potential delay in symptoms. Mrs X was unhappy with aspects of the complaint response and the explanations given, which had raised further specific questions for her.

The Ombudsman declined to investigate and considered that the Health Board had provided a detailed response which addressed the matters that had previously been raised by Mrs X. However, its complaint response had raised further issues and questions for Mrs X, which the Health Board had not had an opportunity to consider and respond to.

The Health Board agreed to within 30 working days provide Mrs X with a detailed written response to the questions raised in her complaint submitted to the Ombudsman.

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

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 202003637 - Report issued in January 2021

Ms Z complained on behalf of Ms A about the delay in the transfer of mental health care co-ordination from Bristol to Cardiff, because the Health Board had failed to make the necessary arrangements. Ms Z explained how the delay was impeding Ms A's access to services and personal progression and that the continued uncertainty was impacting on Ms A's mental wellbeing. The Ombudsman found that discussions about transfer of Ms A's care began in 2017, and in 2019 the Health Board agreed in principle to the transfer. However, despite receiving confirmation that services in Bristol were willing to fund Ms A's access to mental health services in Cardiff, the Health Board had not made the necessary arrangements to agree funding, that would allow for Ms A's care to be transferred. In settlement of the complaint, the Health Board agreed within 1 month to offer Ms A an apology for the delays in the transfer of her care, and within2 months to hold the necessary meetings to agree funding, to establish a timeframe for the transfer of care, and to promptly communicate the outcome to Ms A.

A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital
Case Number: 202003825 - Report issued in January 2021

Mrs A complained that the Medical Centre had failed to carry out further tests or refer her child for specialist treatment following her presentation with a jaundiced appearance and other symptoms. Mrs A also complained about a lack of clear communications between the Medical Centre and the Specialist Hospital in Birmingham ("the Hospital"). Lastly, Mrs A complained about one of the GPs' summary of a

consultation she had with her regarding her child's ongoing treatment.

The Ombudsman, having consulted with his internal Professional Adviser, found that the initial consultations were reasonable. He also recognised that the Medical Centre had reflected on Mrs A's views regarding communications between it and the Hospital and was satisfied that he was unlikely to be able to achieve anything further for Mrs A regarding that part of her complaint.

The Ombudsman was, however, concerned that Mrs A was unhappy with the summary of a consultation that she had with one of the GP's at the Medical Centre. He therefore, contacted the Medical Centre. The Medical Centre agreed to:

a) Place a note on Mrs A's child's medical record noting that the complainant disagreed with the Doctor's summary of the disputed consultation; and
b) write a letter to Mrs A providing a copy of the note placed on her child's medical record.

This will be completed within 20 working days of the date of this decision letter. The Ombudsman believes that this will resolve the complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202003899 - Report issued in January 2021

Mrs X's complaint concerned the care that was afforded to her late mother by Betsi Cadwaladr University Health Board ("the Health Board") in September 2019 and her concerns that her mother's end of life care was ignored due to her alcohol issues. Whilst she had received the Health Board's response to her complaint, she remained dissatisfied with the outcome and explained to the Ombudsman that a number of issues remained outstanding.

The Ombudsman took into account that the Health Board had provided a response to Mrs X's complaint in August 2020 which fully addressed a number of issues raised. However, he concluded that it would be helpful for the Health Board to provide a further written response in relation to the following:

a) Why Mrs X's mother was not on oxygen on admission onto Medical Assessment Unit.
b) Whether her mother's Idiopathic Pulmonary Fibrosis (IPF) specialist was contacted upon her admission.
c) Clarification as to whether the IPF made her mother poorly and its advancement.
d) An explanation of the rationale for not seeking support from the Countess of Chester Hospital in the early days.

The Health Board agreed to provide Mrs X with a written response to the outstanding issues within 30 working days from the date the Ombudsman issued his decision.

Cardiff and Vale University Health Board -Clinical treatment in hospital
Case Number: 202003630 - Report issued in February 2021

Mr A complained that Cardiff and Vale University Health Board ("the Health Board") failed to provide him with a copy of a specific CT scan, discussed with him by a consultant during an appointment in April 2019.

The Ombudsman found that whilst the Health Board had provided Mr A with a CD containing his radiology images, the CD contained approximately 2000 images, which proved difficult for Mr A to identify the scan concerned.

The Ombudsman contacted the Health Board and it agreed to, within 20 working days:

- Provide Mr A with a copy of the radiology image that was discussed with him during his

appointment with a consultant in April 2019. The image provided should relate to the specified appointment only.

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

Hywel Dda University Health Board & a Dental Practice within the Health Board's area - Clinical treatment outside hospital

Case Number: 202003886 - Report issued in February 2021

Mr X complained that Hywel Dda University Health Board ("the Health Board") and a Dental Practice ("the Practice") within the Health Board's area had not provided a response to why Mr X was deregistered as a patient at the Practice. Mr X also complained about issues to do with his original treatment for dentures, the alleged faulty nature of the denture, the rectification work, the alleged failure to refer for emergency work and the possibility that the Health Board might have had some responsibility to provide emergency care.

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

By 17 March 2021:

The Health Board and Practice should liaise with each other in order to:

- undertake a joint investigation and response which covers both the deregistration issue and the clinical diagnosis and treatment issues.

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

Welsh Ambulance Services NHS Trust - Ambulance Services

Case Number: 202004157- Report issued in February 2021

Ms A complained about non-emergency patient transport services provided by Welsh Ambulance Services NHS Trust ("the Trust"). Ms A was unhappy with the Trust's further response provided, following a complaint to the Ombudsman. Ms A was not confident that the improvements and measures implemented by the Trust would specifically prevent a recurrence of the problems experienced. Ms A wanted to see service users contacted to confirm transport arrangements. Ms A complained the Trust were developing VCS driver recruitment, communication and engagement rather than addressing the issue of insufficient vehicles being available. Ms A sought more specific information about the changes to be made to improve the service and the training that was to be provided, particularly in supporting service users with mental health problems and/or additional needs.

In considering Ms A's complaint, the Ombudsman considered that the Trust's response was broadly compliant with the recommendations made. However, the Trust were able to respond more fully and provide a more detailed explanation addressing Ms A's specific concerns.

The Trust agreed to, within 40 working days, review the Non-emergency Patient Transport policies and processes to consider whether service users could be contacted when transport arrangements are made and/or on the day prior to appointments to confirm the transport arrangements. The Trust also agreed to, within 10 working days of the review, provide Ms A with a detailed response setting out the measures for recognising and supporting the needs of service users suffering with their mental health, the training provided to staff and volunteer drivers to assist them in recognising service users' mental health needs and any changes identified and/or implemented as a result of the review.

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

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 202004498 - Report issued in February 2021

Ms X complained about the treatment her mother, Mrs X, received while in hospital. Specifically, she complained that Mrs X's regular diazepam was suspended during her admission, which caused her to experience leg spasms. Ms X also complained that Mrs X sustained an ankle injury during one such spasm, but that she received no physical examination nor pain relief for what, subsequent to her discharge from hospital, was found to be a fractured ankle.

The Ombudsman found that the Health Board had no record of the incident referred to and both Ms X and Mrs X acknowledged that they had neither sought pain relief nor told staff that Mrs X was in pain following the incident. Accordingly, the Ombudsman declined to investigate this element. However, the Ombudsman asked the Health Board to consider in detail the complaint that the consequences of the suspension of Mrs X's diazepam had not been considered. The Ombudsman asked the Health Board to explain it's rationale in suspending the diazepam and not replacing it with an alternative and, if it concluded that there had been a failing in relation to this, to apologise.

Cwm Taf Morgannwg University Health Board - Health
Case Number: 202005037 - Report issued in February 2021

Mrs X complained that Cwm Taf Morgannwg University Health Board ("CTMUHB") had not referred her to a specialist centre in England for specialist neurological treatment. Mrs X said she was advised in March 2020 that she would be referred, however, she said she is still waiting. CTMUHB said that it is waiting for information from the specialist centre before the funding can be approved.

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

- A senior manager at CTMUHB will pursue the request for information from the specialist centre if this is not received by 1 March 2021.

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

Powys Teaching Health Board - Clinical treatment in hospital
Case Number: 202005119 - Report issued in February 2021

Ms X complained that there has been a significant delay in the Health Board concluding an investigation into concerns regarding the delay in referring her for IVF Treatment.

The Health Board agreed with the Ombudsman to undertake the following in settlement of her complaint:

- Commence a service complaint about the standard of its complaint handling.
- Issue Ms X an apology for the delay in concluding its investigation **by 22 March 2021**.
- Issue its "Putting Things Right" response **by 22 March 2021**.

Ceredigion County Council - Services for older people
Case Number: 202005159 - Report issued in February 2021

Ms X to the Council about the care and treatment her mother received at a care home. In particular the circumstances surrounding a fall and a data protection breach.

At the time of bringing the complaint the Council had not concluded its complaint investigation. It acknowledged to the Ombudsman that there were delays which were partly due to additional issues being raised by Ms X.

The Council agreed to issue its complaint response no later than **8 March 2021**.

Hywel Dda University Health Board & a Dental Practice within the Health Board's area - Clinical treatment outside hospital

Case Number: 202005261 - Report issued in February 2021

Mr X complained that Hywel Dda University Health Board ("the Health Board") and a Dental Practice ("the Practice") within the Health Board's area had not provided a response to why Mr X was deregistered as a patient at the Practice. Mr X also complained about issues to do with his original treatment for dentures, the alleged faulty nature of the denture, the rectification work, the alleged failure to refer for emergency work and the possibility that the Health Board might have had some responsibility to provide emergency care.

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

By 7 April 2021:

- The Health Board and Practice should liaise with each other in order to undertake a joint investigation and response which covers both the deregistration issue and the clinical diagnosis and treatment issues.

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

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 202000447 - Report issued in March 2021

Ms A complained about the care given to her late father, Mr B, by Betsi Cadwaladr University Health Board. She said that the Health Board had failed to diagnose Mr B's lung cancer within a reasonable time frame after a chest CT scan ("the scan") and to enable him to make an informed decision about chemotherapy. She also complained that the Health Board had failed to respond to Mr B's related complaint in an open, honest and timely manner.

The Ombudsman found that the Health Board had not issued an interim response to Mr B, in accordance with the relevant complaint handling regulations ("the Regulations"), even though it had accepted that it had breached its duty of care to him because its review of the scan had been delayed and that it had initially considered that he might have suffered harm as a result. The Ombudsman noted that this failure meant that the redress arrangements outlined in the Regulations ("the redress arrangements") were not engaged. He also found that the Health Board had determined, without obtaining advice from an independent clinical expert, that there was no qualifying liability (harm caused by, or in connection with, the care provided) in Mr B's case. He considered that those complaint handling failings were significant and at odds with the principle of procedural fairness. He was of the view that both Mr B and Ms A had suffered an injustice, in the form of uncertainty and unfairness, because of these failings.

The Ombudsman decided that it would be appropriate to try settling Ms A's complaint. The Health Board subsequently agreed to write to Ms A, within 2 weeks of agreeing to do so, to apologise for its complaint handling failings, to confirm that it would consider her clinical care concerns in a manner akin to the redress arrangements, and that doing that would involve the joint instruction of an independent clinical expert and the provision of free legal advice for her. It also agreed to consider Ms A's clinical care concerns in the way identified and to start doing that within 4 weeks of agreeing to do so. Finally, it agreed to take action to ensure, within 6 weeks of agreeing to do so, that it responds to complaints in accordance with the Regulations, if it considers that there is, or that there may be, a qualifying liability. The Ombudsman considered that the action that the Health Board had agreed to take was reasonable. Accordingly, he regarded Ms A's complaint as settled.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 202004742 - Report issued in March 2021

Mrs X attended one the Health Board's hospitals on or around 2 September 2020 to visit her father. She

complained that upon arriving on the ward, she was not informed that her father had passed away. She therefore saw her decesased father without being prepared.

The Ombudsman noted that the Health Board's representative had attended a meeting with Mrs X and had provided her with a written response dated 19 November 2020. The Health Board confirmed that its investigation had identified a breach in the duty of care as Mrs X was not prepared fully prior to seeing her father for the last time. However, the Health Board omitted to confirm whether it considered the breach of duty had caused harm. The Ombudsman noted that the Health Board was required to respond to Mrs X's complaint in accordance with the regulations known as the "Putting Things Rights" scheme and it was obliged when notified of a concern that alleged harm had been caused, to consider whether there was a "qualifying liability" on its part.

Following a discussion of the complaint, the Health Board agreed to undertake the following action in settlement of the complaint:

To further investigate Mrs X's complaint and provide her with a written response under the Putting Things Right scheme within 30 working days from the date on which the Ombudsman issued his decision.

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202004758 - Report issued in March 2021

Mrs A complained that she had an adverse reaction to local anaesthetic prior to an arranged surgical procedure in July 2018. Following this adverse reaction she later underwent the procedure under general anaesthetic. She was, however, concerned that the Health Board failed to refer her to an allergy clinic in order to investigate her initial adverse reaction. She also complained that the Health Board failed to deal with her complaint in a timely manner between 2019 and 2020.

The Ombudsman assessed her complaint and, having exercised some discretion regarding the delay in submission of her complaint, considered the issues raised and outcomes sought by her to resolve the complaint. He was of the view that an investigation would be unlikely to achive anthing further for her but felt that the overarching concern was to ensure that her medical records reflected her current condition. He contacted the Health Board and it agreed to:

1) Write a letter to the complainant re-confirming its apologies for any confusion and delays caused during its interactions with her over the period mentioned in her complaint.
2) Provide her with a copy of the alert that has been included on her medical record for future reference should she require medical treatment.

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

Swansea Bay University Health Board - Clinical treatment in hospital
Case Number: 202004862 - Report issued in March 2021

Mrs X complained to the Ombudsman about the length of time she had been waiting for surgery on her gall bladder and to repair a hernia. This Mrs X complained, amounted to some four and a half years (with some time discounted because of her unavailability for various reasons). Mrs X also complained that the Health Board had taken her off the waiting list for knee replacement surgery at her request despite her not having requested it.

The Health Board explained the reasons for the delay in undertaking Mrs X's surgery including the fact that her other health conditions meant that due to the need to ensure that there is High Dependency or Intensive Care Unit availability associated with her surgery, means it has to be undertaken in Morriston Hospital. It also confirmed that presently Morriston Hospital was only treating the most clinically urgent case whilst working through the COVID pandemic which meant it was unable to anticipate when Mrs X's would be scheduled for surgery. The Health Board confirmed that Mrs X is the patient that has been

longest on the waiting list for General Surgery.

Considering the length of time Mrs X had been waiting for her gall bladder surgery and hernia repair and her position the waiting list, the Health Board that agreed within four weeks it would:

a) write to Mrs X to apologise for the lengthy delay that she has experienced in receiving her treatment and to confirm that once the Health Board begins to re-schedule surgery her case will be treated as a priority given her position on the waiting list.

The Health Board has also agreed within four weeks it would:

b) ask Mrs X to confirm whether she wishes to stay on the waiting list for knee surgery. The Health Board has agreed that if Mrs X does wish to stay on the waiting list for knee surgery, it will re-instate heron the list at the same point as she would have been at if the miscommunication between her and the Health Board had not occurred.

Betsi Cadwaladr University Health Board - Clinical treatment outside hospital
Case Number: 202004957 - Report issued in March 2021

Ms X complained that Betsi Cadwaladr University Health Board ("BCUHB") had not fully addressed her questions and concerns in relation to the diagnosis and treatment of her late mother.

BCUHB agreed to undertake the following in settlement of Ms X's complaint by 31 March 2021
BCUHB will issue a further response to Ms X to address her outstanding questions and concerns in relation to a cancer diagnosis, and the lack of review of scans and x-rays in relation to her mother's *pulmonary disease*.

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

A GP Practice in the area of Cardiff & Vale University Health Board - Clinical treatment outside hospital
Case Number: 202005095 - Report issued in March 2021

The Ombudsman received a complaint from Mrs A saying that the Surgery had changed her repeat prescriptions from monthly to weekly without prior notice or explanation.

The Ombudsman found that the Surgery did not fully explain the rationale behind the changes in prescribing Mrs A's medication.

- The Surgery agreed to take the following action to resolve the complaint:

To arrange a meeting with Mrs A, as soon as is practicable given the current situation, to discuss to all her outstanding concerns.

Cardiff and Vale University Health Board - Clinical treatment in hospital
Case Number: 202005109 - Report issued in March 2021

Ms X complained that Cardiff and Vale University Health Board ("the Health Board") had not addressed all the concerns and questions put forward regarding a Lumbar Puncture procedure where a blood sample was not taken to complete the analysis. This left Ms X confused about the process and the inconclusive results.

As a result of the identified issues the Health Board has agreed to undertake the following by **31 March 2021**:

- Provide Ms X with a full and comprehensive response to the challenges raised in her email to the Public Services Ombudsman for Wales's office dated 28 January 2021.

A Practice in the area of Swansea Bay University Health Board - Clinical treatment outside hospital
Case Number: 202005632 - Report issued in March 2021
Mr A complained about the practice's repeat prescription services saying there was an error with the medication he received. Mr A also complained that the Practice did not provide an explanation or apology for the prescribing errors.

The Ombudsman found that the Practice did not address Mr A's concerns.

The Practice agreed to undertake the following recommendations:

1) To undertake a review of the complaint and provide Mr A with a full explanation of the circumstances which led to the prescribing errors
2) To offer a meaningful apology to Mr A
3) To reassure Mr A that such an occurrence will not happen again

Aneurin Bevan University Health Board - Clinical treatment in hospital
Case Number: 202005667 - Report issued in March 2021
Mrs X complained about the Health Board's discharge planning process in relation to her mother between the period October 2018 and January 2020. She said that due to her mother's mobility, it was not always safe for her to be discharged from hospital.

The Ombudsman noted that Mrs X had made a complaint to the Health Board, and that it had responded by letter dated 21 October 2020. In making a complaint to the Ombudsman, Mrs X outlined in her letter dated 1 March 2021 a number of issues which she considered were unresolved and required further investigation. In light of the issues raised, the Ombudsman considered that it would be helpful for Mrs X to receive a further response from the Health Board.

Following a discussion of the complaint the Health Board agreed to undertake the following action in settlement of the complaint:

- To provide a written response in relation to the issues raised in Mrs X's letter of 1 March 2021 within 40 working days from the date on which the Ombudsman issued his decision.

Complaints Handling

Upheld

Welsh Ambulance Services NHS Trust - Ambulance Services
Case Number: 201905289 - Report issued in January 2021
Mr A complained that the Welsh Ambulance Services NHS Trust's("WAST") mis-categorisation of the family's 999 call meant there was a delay in an ambulance being sent which he said resulted in a significant deterioration of his wife's condition. Mr A said that there was a failure to discuss alternative transport arrangements with him and his wife. He also complained about the delay in WAST's handling of his complaint. The Ombudsman's investigation noted that WAST had acknowledged that the delay was unreasonable and cited pressures on its operational service as the reason for this. Given Mrs A's clinical condition, it would have been inappropriate for WAST to have suggested alternative transport.

The Ombudsman, having taken into account the clinical advice he had received from his Professional Adviser, was satisfied that the failings and deviations in the call handling process, whilst they amounted to a service failure, had not caused an injustice to Mrs A and had not contributed in any significant way to

Mrs A's additional hospital stay. The Ombudsman did not uphold this aspect of Mr A's complaint. In relation to WAST's complaint handling, whilst the Ombudsman found that the complaint response was robust and identified learning points, he considered that the delay of some 11 months in providing a complaint response was not reasonable and amounted to maladministration.

The Ombudsman concluded that the delay around complaint handling meant that Mr A and his family were not able to move on from their complaint and in addition might have further contributed to Mr A and the family's dissatisfaction with WAST's explanation. This aspect of Mr A's complaint was upheld. WAST was asked to apologise to Mr A and pay him a sum of £250 for the delay in complaint handling.

Not Upheld

Welsh Ambulance Services NHS Trust - Ambulance Services
Case Number: 201905233 - Report issued in February 2021
Dr A's complaint against the Health Board included the care and management he received from the Out of Hours GP Services ("OOH GP Services") and later in the Emergency Department ("ED"). Dr A also raised concerns about the OOH GP's record keeping as well as the Health Board's handling of his complaint. In relation to WAST, Dr A complained about the delay in his care being prioritised and the resultant delay in the ambulance being dispatched.

The Ombudsman's investigation concluded that care and management by the OOH GP was reasonable and appropriate and did not uphold this aspect of Dr A's complaint. In relation to the ED, the investigation identified that there was a delay in Dr A being reviewed by a doctor and the provision of pain medication and upheld this aspect of Dr A's complaint. In relation to Dr A's concerns about the delayed ambulance response, the Ombudsman concluded that operational and external difficulties had impacted on service provision. He was satisfied that failings and deviations in the call handling process, whilst amounting to a service failure, did not cause an injustice to Dr A and therefore did not uphold this aspect of Dr A's complaint.

In relation to the Health Board's handing of Dr A's complaint, the Ombudsman did not consider the delay to be excessive. However, he was of the view that administratively Dr A's complaint could have been handled better and it was to that extent that this aspect of Dr A's complaint was upheld. Amongst the recommendations the Ombudsman made included the Health Board apologising to Dr A for the failings identified by the Ombudsman's investigation and putting in place measures to address delay and pain management in the ED.

Early Resolution or Voluntary Settlement

Pobl - Funding
Case Number: 202003270 - Report issued in January 2021
Miss X complained that Pobl ("the Association") failed to respond to her complaint in a timely manner; they did not offer her a review of the stage 1 process and omitted the date from the response letter.

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

1) Provide Miss X with an apology for the delay in responding to her complaint and omitting the date from the response letter
2) Provide Miss X with an explanation for the delay and not offering her a review of the Stage 1 process
3) Provide Miss X with a Stage 2 complaint response

The Association has already undertaken the above actions in order to resolve the complaint.

Cwm Taf Morgannwg University Health Board - Health
Case Number: 202003465 - Report issued in January 2021

Ms X complained about the transfer of her father's care to a different hospital. This had resulted in a change of consultant surgeon which she felt had compromised the surgical outcome for her father. She felt that the Health Board had not responded properly to the complaint.
The Ombudsman found that Ms X had sent a further email to the Health Board following her complaint, and it was not clear whether these points had been properly taken into account when the Health Board provided its formal complaint response. The Health Board therefore agreed to:

- Review the issues raised in Ms X's email to the Health Board of 12 May 2020;
- Provide a further formal written response to her on these points of complaint;
- Where issues have already been addressed in previous responses, these would be cross-referenced to ensure that all of the issues had been responded to.

It agreed to provide the further response by Friday 5 March 2021.

Carmarthenshire County Council - Other
Case Number: 202003497 - Report issued in January 2021

Mr J complained about the actions of Carmarthenshire County Council ("the Council") in its handling of his complaint about the Governing Body of a School in its locality. Despite Mr J raising concerns about the impartiality of the Council's appointed Independent Investigator, the Council took the decision to proceed with its investigation.

The Ombudsman found that Mr J repeatedly expressed valid concerns about the impartiality of the Independent Investigator which were not addressed by the Council. He noted that Council's ability to investigate complaints with transparency and fairness is vital to ensuring public confidence in its complaints process. The subject of impartiality is arguably as important as the actual investigation itself for maintaining such.

The Ombudsman contacted the Council and it agreed to:

within 30 working days:

- Appoint an independent and impartial investigator to conduct a full investigation into Mr J's complaint about the Governing Body. If questions are raised by Mr J about the impartiality of the appointed investigator, the Council should be prepared to fully justify its decision and provide reassurance to Mr J about his concerns in this respect

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

Gwynedd Council - Handling of planning application (other)
Case Number: 202003603 - Report issued in January 2021

Mr X complained to the Ombudsman about the actions of the Highways Department in assessing highway safety issues near his home.

The Ombudsman found that the Council had not dealt with Mr X's concern as a formal complaint.

The Council therefore agreed to:

- Provide a formal response to Mr X's complaint about how it considered the highway safety aspects of the area in question.
- Arrange a site visit with Mr X to discuss and assess the ongoing highway safety and access issues he is experiencing, and discuss with him possible resolutions to these.

The Council agreed to undertake this by 31 January 2021.

Flintshire County Council - Environment and Environmental Health
Case Number: 202003797 - Report issued in January 2021

Ms X complained about numerous missed refuse collections from March 2020 onwards. Ms X complained to the Council and discussed the matter during a telephone call in August 2020. One collection was made following this, but there had been no further collections since.

The Council closed the complaint following the telephone conversation, without making a formal response to Ms X. The Council stated that the original issue regarding collections had been resolved. However, the Council had failed to make any further collections since August 2020.

The Council agreed that within 1 month of the date of the Ombudsman's letter, by 4 February 2021, it would:

- Provide an apology to Ms X that she had not received a response to her complaint
- Provide an explanation for this oversight

Provide a complaint response which encompasses the continued issue of missed collections since August 2020.

Flintshire County Council - Childrens Social Services
Case Number: 202003822 - Report issued in January 2021

Mrs X complained that the Council had refused to accept her complaint against social services on behalf of her daughter. Mrs X also complained that the Council had not responded to her email of 29 October 2020, in which she sought clarification on how she could make a complaint on her daughter's behalf.

The Council confirmed that it had failed to respond to Mrs X's email. The Council agreed to complete the following in settlement of Mrs X's complaint by 28 January 2021:

1) Apologise to Mrs X for the failure to respond to her email and provide a response

2) Apologise to Mrs X for the failure to inform her of how she could make a complaint on behalf of her daughter and provide the necessary information to allow her to do so.

Cynon Taf Community Housing Group - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202003831 - Report issued in January 2021

Miss X complained that despite numerous contacts and visits from Cynon Taf Community Housing Group ("the Association"), and agreements from them to carry out the work required in regards to damp and mould issues in her property, her complaints remained outstanding and the issues had not been resolved.

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

- Provide Miss X with an apology for the delay in responding to her complaint
- Provide Miss X with an explanation for the delay
- Provide Miss X with a formal complaint response

The Association agreed to carry out the actions above within14 days of the date of the Ombudsman's letter, by **5 February 2021**.

Betsi Cadwaladr University Health Board - Health
Case Number: 202003935 - Report issued in January 2021

Ms X complained that the Health Board had failed to complete a psychiatric assessment for her son during a hospital admission. She also disagreed with the Health Board's response to her complaint.

The Ombudsman found that, whilst the Health Board had provided a formal complaint response, it had not specifically responded to points raised by Ms X in her original complaint, or following receipt of the Health Board's response.

The Health Board therefore agreed to (by 19 February 2021):

- Provide a further written explanation to Ms X about the specific nature of the psychiatric assessment carried out.

Consider the content of Ms X's email to it of 3 December 2020 and respond to the points contained in that email as necessary.

Aneurin Bevan University Health Board - Poor/No communication or failure to provide information
Case Number: 202003979 - Report issued in January 2021

Mr X complained about the Health Board's handling of his complaint about the care and treatment provided to his late mother and its failure to provide a complaint response.

The Health Board confirmed to the Ombudsman that it had failed to provide a complaint response to Mr X and had not provided regular and meaningful updates. The Health Board agreed to complete the following in settlement of Mr X's complaint by 29 January 2021:

1) Apologise to Mr X for the lack of meaningful updates and for the delay in responding to his complaint
2) Provide Mr X with an explanation for the delay
3) Provide a complaint response.

Cardiff Council - Planning and Building Control
Case Number: 202004038 - Report issued in January 2021

Ms X complained that the Council had failed to provide a response to her complaint regarding tree felling. The Council confirmed to the Ombudsman that it had failed to provide a complaint response to Ms X and had not provided regular and meaningful updates. The Council agreed to complete the following in settlement of Ms X's complaint by 21 January 2021:

a) Apologise to Ms X for the lack of meaningful updates and for the delay in responding to her complaint
b) Provide Ms X with an explanation for the delay
c) Provide assurance to Ms X that staff will be reminded of the importance of keeping complainants informed
d) Provide a complaint response.

Vale of Glamorgan Council - Community Facilities. Recreation and Leisure
Case Number: 202004085 - Report issued in January 2021

Mr Z complained that the Council had not acknowledged or responded to his complaint regarding theft

and damage to public gates in a timely manner.

The Council has agreed to undertake the following actions in settlement of the complaint by 4 February 2021:

a) Provide Mr Z with an apology for the failure to acknowledge his complaint and for the delay in providing a complaint response
b) Provide Mr Z with an explanation for the delay
c) Provide a complaint response

Swansea Bay University Health Board - Health
Case Number: 202004088 - Report issued in January 2021

Mrs X complained to the Ombudsman about a significant delay on the part of Swansea Bay University Health Board ("the Health Board") in responding to her concerns about its treatment and clinical management of her late daughter. She complained to the Health Board on 20 November 2019 but at the time of her complaint to the Ombudsman in December 2020 she was still awaiting a substantive response from the Health Board. She was also concerned that significant periods had elapsed without updates from the Health Board about the progress of its investigations and that it had failed to deliver responses in line with its assurances to her.

The Health Board explained to the Ombudsman that the issues raised by Mrs X were complex and required significant clinical input. It's enquiries into the complaint were also hampered by the onset of COVID-19 and staff sickness. The Health Board offered to provide Mrs X with, within 4 weeks, an ex-gratia payment of £1000 by way of an apology for the extended delay in responding to complaint and for not keeping her updated appropriately. The Health Board also said that it anticipated it would be in a position to provide Mrs X with a complaint response by mid-February. The Health Board also agreed to update the Ombudsman about when it provided Mrs X with its substantive response to Mrs X's complaint.

Hywel Dda University Health Board - Health
Case Number: 202004105 - Report issued in January 2021

Complaint that the Health Board had failed to carry out a thorough investigation. Health Board agreed to the following in settlement.

By 8 February 2021

- Apologise to the complainant for the errors/references made to a different family
- Complete investigation into the concerns, ensuring that the parents are involved in the investigation and facts are correctly reported
- Issue a new complaint response

Hywel Dda University Health Board - Health
Case Number: 202004185 - Report issued in January 2021

Ms X complained that the Health Board had failed to provide a response to her further complaint about the delay in her obtaining a rheumatology appointment and the treatment she received.

The Health Board confirmed that whilst it had provided a response to Ms X's initial complaint, it had failed to respond to Ms X's further complaint. The Health Board agreed to complete the following in settlement of Ms X's complaint by 29 January 2021:

a) Apologise to Ms X for the delay in providing a further complaint response
b) Provide an explanation for the delay
c) Provide a complaint response.

Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures
Case Number: 202004190 - Report issued in January 2021
Mrs X complained about the inpatient care and treatment provided to her sister, Ms Y, in 2019. Mrs X was dissatisfied with the Health Board's response to her concerns.

The Ombudsman found that the Health Board's management of Mrs X's complaint resulted in an avoidable protracted complaints process and a delayed response, that did not fully address all the concerns raised. In settlement of the complaint the Health Board agreed to offer Mrs X an apology for the miscommunication and delay in providing a response to her concerns, to offer Mrs X the opportunity to clarify the outstanding concerns about the care and treatment provided to Ms Y and provide a response to the outstanding concerns.

Hywel Dda University Health Board - Health
Case Number: 202004746 - Report issued in January 2021
Ms P complained that the Health Board had failed to respond to her complaint about the treatment provided to her following a car accident. She made her complaint in June 2020.

Health Board agreed to the following:

By 31 March 2021

- Apologise to complainant for the delay.

Issue a response, even in the circumstances that a GP position is not obtained.

Flintshire County Council - Pest control/Dog nuisance/Fouling
Case Number: 202004071 - Report issued in February 2021
Miss X complained that Flintshire County Council ("the Council") did not provide her with all the relevant information regarding its Pest Control Service. This meant she was left at a disadvantage and experienced a financial loss.

The Council told Miss X that it could offer a Pest Control Service which would be available in approximately 3 days. However, she was not told that she could pay more for a quicker service or pay less and wait for the Council provided service.

In recognition of this the Council agreed to undertake the following by 26 March 2021:

- Pay Miss X the sum of £100

Wrexham County Borough Council - Care homes
Case Number: 202004097 - Report issued in February 2021
Mr X complained about the Council's response to an Independent Stage 2 report into concerns he raised about the care provided to his father at a Care Home. He complained that the Council had not carried out the recommendations detailed in the Stage 2 report.

Following enquiries from the Ombudsman, the Council noted that it had omitted to share the details of its actions to implement the recommendations. It had promised to share its Action Plan with Mr X but had not done so. It apologised for this oversight.

The Council therefore agreed to:

- Contact Mr X and provide a copy of the Action Plan to him, updated to reflect the actions that have been taken in response to his complaint

Ensure that he has a written apology from the Care Home.

Betsi Cadwaladr University Health Board - Health
Case Number: 202004256 - Report issued in February 2021

Mrs A complained to the Ombudsman about the Health Board's management of her complaint about the inpatient care and treatment provided to her late mother. Mrs A explained how she was unhappy with the delay in the Health Board's response and how it has impacted her and her family.

The Ombudsman found that the Health Board had not provided Mrs A with meaningful updates to her complaint that was submitted in February 2020, and that it had not provided Mrs A with complaint response.

The Ombudsman contacted the Health Board and it agreed to offer Mrs A an apology for the lack of updates and to provide her with a complaint response within 20 working days.

Caerphilly County Borough Council - Childrens Social Services
Case Number: 202004562 - Report issued in February 2021

Miss X complained about the Council's failure to provide a complaint response following her Stage 2 complaint about the removal of her children by Social Services.

The Council confirmed to the Ombudsman that it had failed to acknowledge Miss X's Stage 2 complaint in writing. The Council agreed to complete the following in settlement of Miss X's complaint by 16 March 2021:

a) Apologise to Miss X for the failure to acknowledge her complaint in writing
b) Provide Miss X with an explanation for the oversight
c) Provide a Stage 2 complaint response.

Swansea Council - Various Other
Case Number: 202004569 - Report issued in February 2021

Miss X complained about dangerous cycling and poor signage in the Marina in Swansea, and the Council's failure to address the issues raised.

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

- Provide Miss X with a Stage 2 complaint response - this should include a response to Miss X's concerns as to who is responsible for the issues raised in the complaint, the Police or the Council.

The Council agreed to carry out this action within 4 weeks of the date of Ombudsman's letter.

Carmarthenshire County Council - Unauthorised development - calls for enforcement action etc
Case Number: 202004597 - Report issued in February 2021

Mr X complained about the Council's handling of his concerns in relation to a planning matter and lack of enforcement action against his neighbour.

Whilst the Council acknowledged its shortcomings in relation to the use of a private garage as a business, the Ombudsman found the Council had not considered how the matter would be rectified. The Council agreed to complete the following in settlement of Mr X's complaint by 5 March 2021:

a) Formally record the rationale for not taking enforcement action against the use of the garage and

confirm to Mr X when this has been done

b) Provide reassurance to Mr X that the Council will consider enforcement action afresh in the event that usage of the garage as a business increases to an unacceptable level.

Cardiff Council - Various Other
Case Number: 202004639 - Report issued in February 2021

Miss X complained that the Council had failed to provide a response to her complaints about her missed refuge collections.

The Council confirmed to the Ombudsman that it had failed to escalate Miss X's concerns in line with its complaint's procedure. The Council agreed to complete the following in settlement of Miss X's complaint by 16 February 2021:

a) Apologise to Miss X for the failure to escalate her concerns to a formal complaint
b) Provide Miss X with an explanation for the oversight
c) Provide assurance to Miss X that this will be raised with staff to enable lessons to be learnt

Provide a complaint response.

Betsi Cadwaladr University Health Board - Health
Case Number: 202004705 - Report issued in February 2021

Ms X complained that Betsi Cadwaladr Health Bord ("the Health Board") had not provided a formal response to her complaint raised in May 2020.

As a result of the identified delays the Health Board have agreed to undertake the following by **26 February 2021**:

- To issue a full response via the Putting Things Right (PTR) process

Swansea Council - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202004777 - Report issued in February 2021

Ms X complained about the Council's handling of her complaint about the dangerous communal flooring and that the repairs undertaken were not adequate as it was continuing to cause a trip hazard.

The Council confirmed that while it had provided a Stage 2 complaint response to Ms X, it did not adequately address the trip hazard. The Council arranged for a further site inspection and agreed to complete the following in settlement of Ms X's complaint by 19 February 2021:

- Apologise to Ms X for the failure to adequately address the trip hazard in its complaint response
- Replace the missing floor tiles that were identified during the inspection on 27 January 2021.

Swansea Council - Childrens Social Services
Case Number: 202004877 - Report issued in February 2021

Dr X complained about the Council's refusal to progress his complaint about Children Services to Stage 2 of its Social Services complaints procedure following his request to do so.

The Council confirmed to the Ombudsman that it had declined to progress the matter to Stage 2 as there were concurrent court proceedings under consideration. The Ombudsman was concerned that, under the relevant regulations the Council is obliged to inform the complainant in writing that, where the concurrent consideration has been discontinued or completed, the complainant can resubmit the complaint to the Council no later than 6 months after the concurrent matter has ended. It had not done so in Dr X's case.

The Council agreed to complete the following in settlement of Dr X's complaint by 23 February 2021:

- Apologise to Dr X for the failure to inform him of his right to bring his complaint back to the Council once the Court proceedings had concluded
- Consider Dr X's complaint under Stage 2 of the Social Services complaints process
- Establish which head of complaints set out in Dr X's submission are matters which have been considered by the Court and which can be investigated
- Provide an individual explanation as to why any heads of complaint cannot be investigated.

Swansea Council - Parks. outdoor centres and facilities
Case Number: 202005184 - Report issued in February 2021

Mr X complained that his disabled vehicle was refused access into an amenity site. He had made a complaint to the Council about this but had not received a response.

The Council acknowledged to the Ombudsman its failings in dealing with the matter appropriately. It agreed to undertake the following in settlement of the complaint: -

- Formally acknowledge Mr X's complaint, to apologise and explain the reasons for the delay by 19 February 2021;

Formally consider this issue under the complaints

Cardiff Council - Environment and Environmental Health
Case Number: 202005216 - Report issued in February 2021

Mr X complained that Cardiff Council's ("the Council") waste management collections team had not returned his bins to the spot they are supposed to be in accordance with the Council's assisted living scheme.

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

By 16 March 2021:

- The Council will provide Mr X with a written apology for the inconvenience he has suffered.
- The Council will provide its written assurances that this matter will be logged with the collections team manager to ensure that its staff are aware of Mr X's request for his bins to be brought back up his garden steps.
- The Council will arrange for the collections manager to regularly review this matter to ensure compliance.

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

A GP Practice in the area of Hywel Dda University Health Board - Health
Case Number: 202005283 - Report issued in February 2021

Mrs X complained that the GP practice had not responded to her further complaint letter sent to it in October 2020 asking additional questions.

The GP practice agreed to undertake the following in settlement of Mrs X's complaint:

- By 11 March 2021, to provide Mrs X with a substantive written response to address her outstanding questions / concerns.

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

Trawsfynydd Community Council - Cemeteries/Graves/Headstones
Case Number: 202004014 - Report issued in March 2021

Dr X complained that the Council had refused to allow his mother to be buried at Pencefn and Salem Cemetery ("the Cemetery") as per her wishes in March 2020which were contrary to the Cemetery rules. The Council considered that Dr X's mother was not eligible to be buried at the Cemetery because she had not been resident in the area 5 years before her death. Dr X also complained about the Council's management of his complaint.

The Ombudsman found that the Cemetery rules applicable at the time of Dr X's mother's death were incorrectly applied. In March 2020, Dr X's mother, met the Council's threshold to be buried at the Cemetery, and its interpretation of its rules were contrary to those available and published, which allowed for a burial if the individual had lived in the community for 5 years or more, which was the case. This was a shortcoming. Additionally, the Ombudsman found that there were shortcomings in the Council's management of the complaint because it had not provided a substantive formal response, which led Dr X to consider that it had not been considered properly.

The Ombudsman was pleased to note that the Council agreed, as a resolution to the complaint, to provide a formal complaint response within a month for the shortcomings identified. The Council also agreed within 8 weeks to discuss the findings at its appropriate subcommittee, create and publish its complaint process and internal guidance on its operation of complaints received.

Wrexham County Borough Council - Neighbour disputes and anti-social behaviour
Case Number: 202004035 - Report issued in March 2021

Mr and Mrs X complained about neighbour harassment, who is a Council tenant, particularly allegations of physical/verbal abuse and issues around the placement of bins which had been ongoing for numerous years. Mr and Mrs X considered that the Council should have taken further action against the tenant for breaches of tenancy including protecting them from harassment which they had asked the Council to do.

The Ombudsman found that certain aspects of the complaint were matters outside of his jurisdiction. For matters that were in jurisdiction, documentation showed that appropriate action was taken in respect of verbal abuse and that the complainant was adequately informed. With respect of the complaint about the placement of bins and that this amounted to harassment, the Ombudsman considered that a further response could be provided to the complainant as matters had been ongoing since October 2020.

The Council agreed within a month to provide Mr and Mrs X with a substantive response to their bin and harassment concerns (including a summary of any action taken) and to document on record its deliberations about any protection from harassment considerations. The Ombudsman was pleased to note the action the Council would take to resolve the complaint.

Hywel Dda University Health Board - Health
Case Number: 202004160 - Report issued in March 2021

Mr X complained to the Ombudsman about a failure by his GP Practice (which is managed by the Health Board) to investigate and respond to a complaint he made about the way in which a member of the Practice staff spoke to him. He also complained that his GP records had been defaced and that the Health Board were unreasonably restricting his registration with another GP practice within his GP Practice catchment area.

The Ombudsman found that the Health Board was entitled to require that Mr X register with a GP Practice within his GP practice catchment area even though there were GP Practices that were closer to his home but which were outside his GP Practice area. It was not possible to identify the nature of the defacement of Mr X's GP notes and any concerns about this would need to be raised with the Health Board and any issues about the inaccuracy of his records would ultimately need to be referred to the Information Commissioner.

Finally, the Ombudsman found no reliable evidence that the GP Practice and the Health Board had investigated and responded to Mr X's complaint about the manner in which a member of his Practice spoke with him. Given that the event in question occurred in early 2019 and that the member of staff involved in the incident and the person that would have been responsible for investigating it had left the Practice, the Ombudsman accepted that there would be little benefit in investigating this matter now. The Health Board agreed to apologise for this failing and provide some additional information to Mr X.

Welsh Ambulance Services NHS Trust - Ambulance Services
Case Number: 202004320 - Report issued in March 2021

Mr A complained that the Welsh Ambulance Services NHS Trust had failed to respond adequately to his complaint about care it provided (through its 111 and 999 services) to his late mother on 27 October 2019.

The Ombudsman was concerned that the Trust had not captured Mr A's key concerns when recording his complaint, and had failed to arrange a joint response to aspects of the complaint which related to a different Health Board. As a result Mr A's complaint was not fully addressed and he was put to the avoidable time and trouble of repeating his complaint to another organisation.

Following engagement with the Ombudsman, the Trust agreed to undertake the following actions within 1 month:

- Write to Mr A, confirming that it will carry out a fresh investigation into his complaint with reference to key events and issues identified by the Ombudsman
- Apologise to Mr A in writing for shortcomings in the original complaint response
- Make a financial redress payment of £250 to Mr A in respect of time and trouble.

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

Pembrokeshire County Council - Housing
Case Number: 202004763 - Report issued in March 2021

Mr X complained that the Council had not responded to his complaints in a timely manner, and had not responded adequately to the issues he had raised concerning housing issues.

I was concerned about the delays in providing Mr X with a full response.

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

- Provide Mr X with an apology for the delay in responding to his complaint
- Provide Mr X with a full stage 2 investigation report. The investigation would need to ensure that the Council consider both the substantive issues of the complaint and the Council's own complaints handling.

The Council agreed to carry out these actions within 4 weeks of the date of the Ombudsman's letter.

A private care home in the area of Swansea Council - Care Homes
Case Number: 202005005 - Report issued in March 2021

Mr C complained that a private care home in the area of Swansea Council ("the care home") failed to provide a response to his complaint about the procedure it followed when it reported an alleged assault on his wife to external agencies.

The Ombudsman found Mr Cs complaint was suitable for investigation under the care home's internal

complaints process as it concerned the policies and procedures followed by the care home in determining that the incident should be referred to external agencies for investigation.

The Ombudsman contacted the care home and it agreed to, **within 20 working days:**

- Provide Mr C with a comprehensive response to his complaint, detailing the policies and procedures followed by the care home, which resulted in the decision being made to report an alleged assault of his wife that occurred on 8 January 2020, to external agencies on 6 February 2020.

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

Conwy County Borough Council - Various Other
Case Number: 202005065 - Report issued in March 2021

Mr X complained that Conwy County Borough Council ("the Council") had failed to maintain a coastal path to a standard that allows accessibility for wheelchair users. He also raised concerns about complaint handling and matters not being addressed at stage 2 of the Council's complaints process.

As a result of the concerns raised the Council has agreed to undertake the following in settlement of the complaint:

- Agreed a date to meet Mr X at the site in order to draft a plan of repairs to assist with access (where the Council reasonably can and are the relevant land owner) and to discuss ongoing maintenance concerns and how the Council can adapt its operations accordingly to meet residents' needs

If following this meeting Mr X remains dissatisfied with the Council's response and should Mr X wish to escalate matters to Stage 2 this will be considered in the usual manner

Swansea Council - Services for People with a disability inc DFGs
Case Number: 202005334 - Report issued in March 2021

Mr A complained about the recommendations made by an Occupational Therapist ("OT") in their assessment report. Mr A complained that the OT did not fully consider what adapatations were necessary to meet the needs of a family member's ability to live independently within their own home.

The Ombudsman found that Swansea Council did not fully explain how the OT had assessed the needs of the family member and what policies and procedures has been relied upon to set out their recommendations.

In response to these concerns Swansea Council agreed to provide a comprehensive response to Mr A explaining the rationale behind the OT's recommenations.

Bridgend County Borough Council - Refuse collection. recycling and waste disposal
Case Number: 202005403 - Report issued in March 2021

Mr W complained that in December 2020, Bridgend County Borough Council ("the Council") stopped collecting his household waste from the rear of his property, as it had done for the previous 8/9 years. Mr W said that the Council informed him that he had to present his waste at the front of his property. Mr W said that he has a number of health issues, which would make that task very difficult for him.

The Ombudsman found that there was no evidence that the Council had considered Mr W's rights under the Equality Act 2010. The Act says that if an individual has a disability, reasonable adjustments should be made by local authorities to ensure that the person receives the same services, as far as practicable, as

someone who does not have a disability.

The Ombudsman contacted the Council and it agreed to, within 20 working days:

- Undertake an assessment of Mr W's needs regarding his refuse collection, in accordance with the Equality Act 2010.

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

Vale of Glamorgan Council - Childrens Social Services
Case Number: 202005419 - Report issued in March 2021

Miss A complained about the Vale of Glamorgan Council's("the Council") decision, provided on 17 February 2021, whereby it declined to investigate her complaint about its Social Services Department, under the Social Services Complaints Procedure, on the basis that it was deemed to be out of time for investigation.

The Ombudsman found that the Council failed to adhere to The Social Services Complaints Procedure (Wales) Regulations 2014 ("the Regulations") in its handling of Miss A's complaint. Despite Miss A submitting her complaint within the 12 month statutory timeframe, the Council failed to notify her that she could proceed directly to the formal investigation stage, failed to respond to her complaint within the prescribed timeframe and failed to communicate effectively with Miss A between September and December 2020. The Ombudsman concluded that, taking into consideration the failings on the part of the Council, Miss A's complaint would not be considered out of time for investigation.

The Ombudsman contacted the Council and it agreed, within 5 working days, to:

- Commence a formal investigation into Miss A's complaint, in accordance with Regulation 17 of The Social Services Complaints Procedure (Wales) Regulations 2014.

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

Powys County Council - School Transport
Case Number: 202005479 - Report issued in March 2021

Mr X complained that the Council failed to follow its internal appeals and complaints process when considering an application for free school transport.

The Council agreed witih the Ombudsman to restart the appeals process no later than 12 March 2021.

Flintshire County Council - Planning and Building Control
Case Number: 202005491 - Report issued in March 2021

Ms X complained to the Council in late 2020, and in November 2020 the Council confirmed that the complaint had been escalated to Stage 2 of its complaints process. When Ms X contacted the Council in January 2021 she was advised that her complaint had been closed.

The Ombudsman was concerned that the complaint was closed without notifying Ms X. The Council told the Ombudsman that following escalation it wrote to Ms X requesting additional information but did not get a response. It consequently closed its file.

The Ombusdman arranged with Ms X to respond to the Council's email of 15 December, which she did on 23 March. The Council has apologised for failing to follow up its email and notify her of it closing the

complaint and has agreed to issue its response within 20 working days of 23 March 2021.

Cardiff Council - Safeguarding
Case Number: 202005542 - Report issued in March 2021

Mr W complained that Cardiff Council ("the Council") did not fully investigate his complaint against its Social Services department.

The Ombudsman found that the Council had not offered Mr W the opportunity to have his complaint investigated at Stage 2 of its complaints process.

The Council agreed to take the following action in settlement of the complaint:

a) To investigate Mr W's complaint at Stage 2 of its complaints process.

Wrexham County Borough Council - Refuse collection. recycling and waste disposal
Case Number: 202005578 - Report issued in March 2021

Mr X complained that Wrexham County Borough Council ("WCBC") had continually failed to collect his recycling waste on a weekly basis.

WCBC agreed to undertake the following in settlement of Mr X's complaints:

By 23 March 2021:

The Council will:

1) provide a written apology to Mr X for the inconvenience he has suffered
2) provide written assurances to Mr X that this matter will be logged with the collections team manager to ensure that staff are aware of Mr X and to ensure that every effort is made to collect his recycling in future
3) make an agreement with the collections manager to regularly review this matter to ensure compliance.

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

Cardiff Council - Other
Case Number: 202005722 - Report issued in March 2021

Mr & Mrs X complained that Cardiff Council ("the Council") did not provide funding and support during a Special Guardianship Order made by the Family Court that places a child or young person to live with someone other than their parent(s) on a long-term basis.

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

Within 14 days of the Ombudsman's decision letter the Council should:

1) Provide a written apology to the complainants to apologise for not identifying their concerns as a complaint
2) Confirm to the complainants that the Council will consider the complaint in accordable with its statutory social services complaint procedure
3) respond to the entirety of the complaint submitted to the Ombudsman, including explaining any issues that the Council consider not to fall within the Social Services complaints remit.

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

Cardiff Council - Planning and Building Control
Case Number: 202005799 - Report issued in March 2021
Miss X complained that the Council had failed to respond to a written complaint she had submitted. The Council agreed to complete the following actions in settlement of Miss X's complaint:

By 30 April 2021:

1) Provide Miss X with an apology for the delay in responding to her complaint;
2) Provide Miss X with a full explanation as to why her complaint was not progressed;
3) Provide a full response to the original complaint.

Flintshire County Council - Planning and Building Control
Case Number: 202005843 - Report issued in March 2021
Mr W complained that the Council had failed to respond to a complaint he submitted in December 2020. The Council therefore agreed to complete the following actions in settlement of Mr W's complaint:
By 31 March 2021:

1) Provide Mr W with an apology for the delay in responding to his complaint;
2) Provide a full response to the original complaint.

Cardiff Council - Refuse collection. recycling and waste disposal
Case Number: 202005989 - Report issued in March 2021
Mrs X complained that Cardiff Council ("the Council") had regularly missed her mother's waste collections. The Council agreed to undertake the following in settlement of Mrs X's complaint:

Within 3 weeks of the Ombudsman's decision, the Council agreed to provide:

a) a written apology to Mrs X and her mother for the inconvenience suffered
b) written assurances to Mrs X and her mother that this matter will be logged with the collections team manager(s) to ensure that staff are aware of Mrs X's mother's needs and ensure that every effort is made to collect her waste in future.
c) make an agreement for the collections manager(s) to regularly review this matter to ensure compliance.

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

Education

Upheld

Newport City Council - Admissions procedures and appeals
Case Number: 202000205 - Report issued in February 2021
Mrs N complained that Newport City Council ("the Council") incorrectly applied the oversubscription criteria of its School Admissions Policy 2019/20 ("the Policy") in relation to the admission of her daughter. Mrs N said that when a school place became available some months later at the school ("the Primary School") it was given to a child ahead of her daughter on the waiting list who had a sibling attending the Primary School's nursery. Mrs N said that her daughter should have been first on the list, due to her son already attending the Primary School (he was in year 2) and she should have been offered the place.

The investigation found that whilst the Welsh Government's School Admissions Code ("the Code") did not

specifically rule out siblings attending a nursery being taken into account when deciding the admission criteria for attached primary schools, the Ombudsman's view was that the Code's intention was that siblings in nurseries should be excluded and the Council had therefore interpreted the Code incorrectly and misapplied the oversubscription criteria of the Policy. As a consequence of this incorrect interpretation, the Ombudsman concluded that Mrs N's daughter missed out on a place at the Primary School. The Ombudsman upheld Mrs N's complaint.

However, the Ombudsman also determined that because the Code was not explicit about whether siblings in nurseries should be excluded from consideration under school admissions policies, the Council's Policy could not be considered so unreasonable as to be perverse. Therefore, the Ombudsman recommended that the Council should apologise to Mrs N and review the Policy in time for its next annual consultation on admission arrangements to ensure it fully reflected the intentions of the Code. The Council agreed to the recommendations.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

Powys County Council - Environment and Environmental Health
Case Number: 202004776 - Report issued in March 2021
Mr X complained that Powys County Council ("the Council") did not undertake a thorough investigation into reported allegations that he failed to pick up his dog's faeces and that it failed to take account of his disability and circumstances in reaching its conclusion.

The Ombudsman found that the Council had not adequately explained how it had arrived at its decision nor the issues it had taken into account in reaching that decision. The Ombudsman also found that the Council had failed to contact Mr X's personal assistant/carer for their input and also had not sought clarification from Mr X in respect of information he had provided.

The Council agreed (within 20 working days) to apologise to Mr X, contact this PA for information and clearly set out in writing to him, both its decision and detailed rationale. The Ombudsman considered this to constitute an appropriate resolution.

Finance and Taxation

Upheld

Student Loans Company - Funding/student loans
Case Number: 201902610 - Report issued in February 2021
Miss X complained about the time taken by Student Loans Company ("SLC"), through its operating arm, Student Finance Wales, to process her application for a Postgraduate Loan ("PGL") and that the second instalment of the PGL was delayed. Secondly, Miss X complained about the accuracy of the investigation undertaken by the Independent Assessor("IA"). Miss X also complained about a request by SLC to pay back overpayments relating to claims for funding made between 2014 and 2017.

In relation to the first complaint, the Ombudsman found that Miss X wrote to SLC to confirm her address history, however the letter was not accepted by SLC as it did not reference specific dates. The Ombudsman considered the SLC's decision to reject Miss X's letter unreasonable as the letter covered the relevant period that Miss X was required to evidence. The Ombudsman considered that the decision to

refuse the letter amounted to maladministration that had caused Miss X an injustice as it caused a delay in the processing of her PGL application which was likely to have impacted her ability to manage her finances and caused her some anxiety.

The Ombudsman found that the delay experienced by Miss X in receiving the second instalment of her PGL was caused by a system error which could not have reasonably been foreseen or prevented by SLC. Therefore, this element of the complaint was not upheld.

The Ombudsman found that the investigation undertaken by the IA was reasonable. He also concluded that it was reasonable for SLC to request evidence from Miss X to finalise her application for funding. These elements of the complaint were therefore not upheld.

The Ombudsman recommended that SLC apologised and provided Miss X with a financial payment, in recognition of its failure to accept her letter in which she confirmed her address history.

Early Resolution or Voluntary Settlement

Flintshire County Council - Finance and Taxation
Case Number: 202003701 - Report issued in January 2021
Ms X complained to the Ombudsman about the manner in which Flintshire County Council had added additional amount to her rent account in relation rent arrears. Ms X complained that the Council had made an unfair and unlawful decision to add an arrears balance to her rent account in order to withhold and retain a back payment of housing benefit; When she had asked them which legal authority, or on what legal basis, the Council had relied upon to do this, she did not receive a clear response. Ms X was also aggrieved that I having spoken to Flintshire County Council about this issue, she considered their response to have been judgmental, felt belittled by this and that her complaint about this was been ignored or overlooked and that she had received poor customer service from the Council generally.

The Ombudsman found that the explanation the Council provided to Ms X about its authority to amend her arrears was insufficient and that it had failed to address the concerns Ms X raised abut poor customer service she had received. The Council agreed to provide Ms X within four weeks, the following:

- a further response setting out precisely the Council's rationale for the action it has taken in relation to the concerns Ms X raised about the reason and authority for its decision. In providing its further explanation, the Council agreed to clarify the sections of the Housing Benefit (General) Regulations 1987 it relied upon to arrive at its decision in relation to Ms X's case.
- a response to the concerns Ms X raised about the poor customer service as well as an apology for not responding to this issue in the Council's previous responses.

Housing

Early Resolution or Voluntary Settlement

Cardiff Community Housing Association – Housing
Case Number: 202003933 - Report issued in February 2021
Mr X complained that Cardiff Community Housing Association ("the Association") had not repaired an urgent water leak reported in September 2019 until December 2019 and that follow-up decorations and compensation, due to damage to personal property, is yet to be fulfilled.

As a result of the identified delays the Association have agreed to undertake the following by **19 February 2021**:

- To pay Mr X the offered sum of £1081 minus any rent areas
- Detail and agree to an action date for any essential repairs identified by the Association's surveyors in January 2020
- Detail and agree to an action date for previously agreed interior decorating to the living room, bathroom and kitchen
- To complete a full survey on the flat to ensure appropriate standards within the home

Cardiff Council - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202004439- Report issued in February 2021
Ms X complained that Cardiff Council ("the Council") had failed to complete outstanding works at her property to deal with damp and electrical issues.

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

By 8 March 2021:

- The Council will contact Ms X to arrange a date to attend her property to complete the outstanding works, with an aim to complete all works by 30 April 2021.

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

Merthyr Tydfil Housing Association Ltd - Tenancy rights and conditions/abandonment and evictions
Case Number: 202001237- Report issued in March 2021
Mr X complained about a warning letter that Merthyr Tydfil Housing Association Ltd sent to him on 15 June 2020, which said that he had breached the terms of his tenancy agreement during a telephone conversation with a Tenancy Management Officer a few days earlier. Mr X also raised concerns about the way in which MTHA had dealt with his subsequent complaint about the letter.

The Ombudsman concluded that the decision that Mr X had breached his tenancy agreement was one that MTHA was entitled to take and that it had not, at that time, been obligated to have contacted him before issuing its letter. Therefore, he declined to investigate this aspect of the complaint.

Nevertheless, the Ombudsman was concerned that MTHA's response to Mr X's complaint did not provide him with any explanation as to how the decision to not uphold his complaint had been reached, or provide any information about the evidence that had been considered during its investigation. This amounted to maladministration on the part of MTHA. Therefore, he contacted MTHA and it agreed to carry out the following, within 20 working days, in settlement of this aspect of Mr X's complaint:

a) Provide Mr X with a written apology for the lack of explanation for the decision made in the complaint response dated 3 July 2020.
b) Provide Mr X with an explanation that the breach of tenancy conditions notice has a finite lifespan, as it will be held on file for a period of 12 months only, and that a Policy on Dealing with Unreasonable Behaviour or Actions is now in place.

Adra - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202004474 - Report issued in March 2021
Mr X complained that Adra left him with a potentially dangerous electrical installation at his property for a prolonged period of time. Mr X said that Adra was aware of the danger, but failed to inform him.

The Ombudsman found that there was a period between April 2017 and October 2020, when electrical

repair works, deemed to be urgent, were not completed. Whilst Adra said that the delay was due to difficulties in putting a programme of works in place and the appointment of contractors, the Ombudsman was not persuaded that these issues justified the significant delay caused to Mr X.

The Ombudsman contacted Adra and it agreed to, **within 20 working days:**

- Make a financial redress payment of £500 to Mr X in recognition of the fact that during the period from April2017 to October 2020 electrical repair works, deemed to be urgent, were not completed at his property.

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

Bron Afon Community Housing Ltd - Repairs and maintenance (inc dampness/improvements and alterations eg central heating. double glazing)
Case Number: 202005767 - Report issued in March 2021
Mr X complained that the Association had failed to carry out repairs to his garden and despite complaining numerous times he had not received a response from the organisation.
In settlement of the complaint the Association agreed to undertake the following: -

By 30 April 2021

a) Provide Mr X with an apology letter from the CEO for the handling of the work to the garden,
b) Determine how the delays happened and take appropriate action to minimise a recurrence,
c) Offer £50 financial redress to Mr X for his time and trouble in pursuing the complaint,
d) Carry out the repairs to Mr X's garden.

United Welsh Housing Association – Other
Case Number: 202004739 - Report issued in March 2021
Mr X complained that he and the Association had established a rent agreement but that this was not administered as agreed and in January 2021 this resulted in him accruing an additional week's worth of arrears.

Due to the method of collecting the rent payment not being clearly explained the Association undertook the following:

a) Provided Mr X with an apology for the confusion
b) Provided a more detailed explanation of how the monthly rental charge (including previous arears agreement) will be collected
c) Provided details of which months Mr X can expect to pay 5 weeks' worth of rent

Planning and Building Control

Upheld

Flintshire County Council - Handling of planning application (other)
Case Number: 201802418 - Report issued in March 2021
Ms N complained about the refusal and subsequent grant of a Certificate of Lawfulness of Proposed Use or Development (s192 certificate) by the Council in respect of her next-door neighbour's property. She also complained about the grant of retrospective planning consent for the development which had been built other than in accordance with the s192 certificate, and the subsequent application to vary a

condition attached to the consent, restricting its occupation to the current occupant.

The Ombudsman found that the development proposed by the s192 certificate application (an "annexe" containing primary living accommodation to be built in the garden of the next-door property) was not within a class for which planning permission was not required. It was thus not lawful development and the application should therefore not have been granted. When the retrospective application was made to retain the development which had not been built in accordance with the s192 certificate, the planning officer had been influenced by the existence of the s192 certificate; the Ombudsman concluded that, on the balance of probabilities, it was unlikely that permission would have been granted in the absence of the s192 certificate. He concluded there was maladministration, both in the grant of the s192 certificate and in the grant of the retrospective application, and upheld the complaint. Ms N had suffered a loss of privacy which had affected her enjoyment of her home and garden, and diminished the value of her property.

The Ombudsman made the following recommendations:

- That the Council apologise to Ms N for the failings he identified.
- That the Council review whether the conditions attached to the retrospective permission had been complied with.
- That the Council instruct the District Valuer to assess the impact of the development on Ms N's property, and pay her the difference between the value of her property before and after the development.

Not Upheld

Carmarthenshire County Council - Handling of planning application (other)
Case Number: 201902300 - Report issued in March 2021
Mrs A complained that Carmarthenshire County Council's ("the Council") Planning Department failed to consider her complaint that a retrospective planning application in November 2018 was based on the original approved plans. Mrs A also complained that the Council failed to give reasons for not taking objections into account and that inadequate minutes were produced in relation to the Planning Committee meeting held on 15 November 2018. Finally she complained that the Council's complaint handling was not robust.

The Ombudsman's investigation found that the Council did identify, albeit at a later stage, that the planning proposal did not match the given description and that additional wording was required to reflect all the changes. The Ombudsman also found that the Council's Planning Committee did appropriately consider representations made about the planning process and that in reaching their decision they took into account all the planning amendments made. The Ombudsman was also satisfied that the Planning Committee's minutes of the meeting were sufficient and correctly summarised the key points. He was also satisfied that complaint handling was robust. The Ombudsman did not uphold Mrs A's complaint.

Social Services – Adult

Upheld

Flintshire County Council - Services for vulnerable adults (eg with learning difficulties. or with mental health issues)
Case Number: 201903339 - Report issued in March 2021
Mrs P complained about the care given to her late father, Mr Q, during his stay at a care home ("the Care

Home") between December 2018 and April 2019. In particular, Mrs P was unhappy that:

- The Care Home lost Mr Q's clothing despite all items being labelled.
- Mr Q did not have a morning routine and he was often found in bed instead of having been washed and dressed.
- Mr Q lost 11kg in weight during his stay at the home.
- A sensor to inform staff of when Mr Q had left his room was put in the wrong place.
- The Care Home did not inform Mr Q's family of all his falling and choking incidents.

The Ombudsman upheld every element of Mrs P's case. However, shortly after Mr Q left the Care Home, and following an inspection by Care Inspectorate Wales, the Council and the local health board moved the remaining residents out and it eventually closed.

This limited the recommendations the Ombudsman could propose; however, he instructed the Council to apologise to Mrs P and provide her with details of the learning opportunities it had identified following the closure of the Care Home and what action it had taken since to address any shortcomings. The Ombudsman also recommended that the Council make a financial redress payment of £500 to Mrs P in recognition of the identified failings.

Not Upheld

Blaenau Gwent County Borough Council - Services for vulnerable adults (eg with learning difficulties. or with mental health issues)
Case Number: 201900338 - Report issued in February 2021
Ms X complained that Blaenau Gwent County Borough Council ("the Council") did not undertake the assessment process and decision making in line with the Social Services and Well-being (Wales) Act 2014 ("the SSWBA 2014"). As a result, Ms X was not found eligible for direct payments (whereby the individual is paid to enable them to arrange their own services, as opposed to a local authority's direct provision of them) between July 2017 and October 2018, despite a recommendation in October 2018 that she should receive 3 hours of direct payments per week. Ms X said that she should have been eligible following her first assessment.

The Ombudsman found that, based on Ms X's assessment in July 2017, Ms X's personal outcomes and identified needs were capable of being met through the assistance and services available in the community and she was given appropriate information about local services she could access. The Council's actions at this time was appropriate, proportionate and in line with the requirements of the SSWBA 2014. When Ms X was assessed in August and October 2018, new personal outcomes and needs were identified that were different to those previously expressed. The result of this assessment was that Ms X's outcomes and needs were not ones that could be met through the provision of advice, assistance or access to local community services. Ms X had an eligible need and the Council had a responsibility to provide for these needs which was done through the provision of direct payments. The Ombudsman was therefore satisfied that the Council's actions were appropriate and that it acted in accordance with its duties under the SSWBA 2014. He did not uphold the complaint.

Social Services – Children

Upheld

Newport City Council – Safeguarding
Case Number: 201907493 - Report issued in February 2021
Mr and Mrs X complained that the Council's Social Services Department did not appropriately assess,

support or assist their family after their 2 grandsons moved to live with them in December 2018, and that their complaint was not handled properly.

The investigation upheld both aspects of Mr and Mrs X's complaint. Although it found that there was no formal role for Social Services, other than ensuring that the children were safeguarded, it determined that Social Services should have clearly explained to the family the reason for its decisions, and explored with Mr and Mrs X whether they needed any support and what was required. Instead Mr and Mrs X were left to cope alone, which caused them a great deal of stress. It found that Social Services again failed to share information with Mr and Mrs X by not explaining to them what options were available when it re-opened the case in March 2019, and that it failed to contact the family at all after August 2019, even thought it had a clearly recorded plan to do so.

The investigation also found that there was a considerable delay of 4 months when Social Services held on to the response to Mr and Mrs X's complaint for no apparent reason, only providing it to them after it received a Data Subject Access Request from them.

By the time this investigation was concluded, Social Services had already drafted factsheets and put in place a Family and Friends Team to give information to family members who find themselves in a similar position to Mr and Mrs X. It had also completed a review of Child Protection processes and was undertaking a review of the threshold for intervention.

The Ombudsman recommended that the Council should apologise to Mr and Mrs X for the failures to provide them with support and assistance, and for the failure to update the Child Assessment before closing the case. The Ombudsman also recommended that the Council should send Mr and Mrs X a copy of any relevant policies for support, and should pay redress to Mr and Mrs X of £250 for the delay in responding to their complaint. The Council agreed to comply with these recommendations within 2 months.

Not Upheld

Welsh Government - Fostering and Other Looked After Children
Case Number: 202001050 - Report issued in March 2021

Ms V complained that Children in Wales ("CiW"), while undertaking its role as the Independent Review Mechanism ("IRM"), based its review decision to recommend Ms V was not suitable for approval as a foster carer on criteria set out by the British Association for Adoption and Fostering("BAAF"). Ms V said she was not made aware of these competency criteria and she was not given the opportunity to present extra information at the IRM and was denied a fair trial. Ms V also said that information provided by the adoption agency to the IRM was inaccurate and misleading, and the IRM received and considered new information within 24 hours of the review hearing, disregarding its own procedures.

The Ombudsman's investigation found that whilst Ms V had not been informed of the BAAF competencies prior to the IRM, and this was maladministration, Ms V had not suffered significant hardship or injustice as it could not evidenced that the IRM decision might have been different had she been made aware of the competencies. The Ombudsman also found that Ms V was given the opportunity to present extra information at the IRM (that was originally missing) and was therefore given a fair trial.

The Ombudsman also found that whilst some evidence was disputed by both parties, the IRM had sufficient information to reach its unanimous decision. Finally, the Ombudsman concluded that the IRM correctly rejected new information, that the adoption agency wanted considered, within 24 hours of the review hearing.

Ms V's complaint was not upheld.

Various Other

Upheld

Monmouthshire County Council - Recruitment and appointment procedures
Case Number: 201905681 - Report issued in January 2021

Mr X complained about the Monmouthshire County Council's ("the Council") conduct during a recruitment process in 2019. The investigation considered whether the Council followed its internal policies, guidance and protocols, and in addition, whether it adhered to the Disclosure and Barring Service's Code of Practice ("the Code") and the Rehabilitation of Offenders Act 1974 ("ROA").

The investigation found that the Council incorrectly requested an Enhanced Disclosure and Barring Service ("DBS")check with additional barring checks for the post Mr X applied for, and this constituted a breach of the Code and was contrary to the ROA. Furthermore, the investigation found that the Council did not use its reasonable endeavours to ensure that the correct and legally permitted DBS check was requested and this too was a violation of the Code. In addition, the Council's internal policies were not adhered to.

The investigation also found that the Council's actions in how it risk assessed Mr X's suitability for the position and the subsequent withdrawal of his conditional employment offer was not in line with its own internal policies and this, along with a failure to document due process, amounted to maladministration.

The investigation found that Mr X was treated in a manner that was contrary to the spirit of the ROA which is designed to ensure that discrimination does not occur. The investigation found that as a direct consequence of the Council's actions, and the failings identified, Mr X was denied the opportunity of taking up employment with the Council, his spent convictions were disclosed unnecessarily (which potentially constituted a data protection breach) and he was left feeling humiliated and embarrassed.

The Council agreed to provide Mr X with a fulsome apology for the failures identified, to pay a redress sum of£1,700 and to report the incident to the Information Commissioner's Officer. In addition, the Council agreed to revise its internal DBS Policy, ensure potential employees are provided with a copy of the aforementioned policy and arrange refresher training on the DBS legal framework for its Human Resources Department. Finally, it agreed to undertake a review of all recruitment undertaken over the past 2 years to ascertain whether the correct DBS checks had been sought. The Council agreed to inform the Ombudsman of the number of potential applicants who were affected by spent convictions being unlawfully sought and thereafter consider whether it should notify the unsuccessful candidate of the error.

Swansea Council - Safeguarding
Case Number: 202001243 & 202002525 - Report issued in February 2021

Ms A complained that in 2016, Swansea Council failed in its statutory duty to safeguard her children, C and D, following a safeguarding referral from a local authority in England (where their father lived) and also that it failed to work effectively with other agencies. During the investigation, information was received from the Local Government and Social Care Ombudsman (who was investigating Ms A's complaint against the local authority in England ("the Local Authority") that the Council had also received information about C and D from the Local Authority in 2015. Therefore, the Ombudsman used his own initiative investigation power under Section 4 of the Public Services Ombudsman (Wales) Act 2019 ("the Act") to extend his investigation. The investigation also considered whether the Council, in a similar manner to that set out above, failed to act following the receipt of the information in 2015.

The investigation found that the Council failed to consider the need for a strategy discussion and strategy meeting in line with relevant procedures following the receipt of information from the Local Authority in 2016. Consequently, C and D were put at risk by continuing to visit their father. C and D were exposed to

domestic abuse on multiple occasions which caused them emotional harm and distress. In addition, a disclosure made by C to Ms A in 2019 also caused Ms A significant distress. This was an injustice to C, D and Ms A. The investigation found no evidence of maladministration or service failure in relation to the actions of the Council following the receipt of information from the Local Authority in 2015. The investigation also found failures in relation to record keeping which amounted to maladministration. The Council agreed to, within 1 month,

- provide Ms A with a written apology for the failings identified,
- pay Ms A, C and D £1000 each in recognition of the significant distress caused and in recognition of the duration of the injustice and the severity of the injustice.

The Council also agreed, within 3 months, to provide the Ombudsman with evidence of its reviews of the following:

- its procedure for recording and documenting referrals or contact to Social Services,
- its review of the effectiveness of practice in response to concerns generated out of area, its review of the training, guidance and support provided to staff in its Information, Advice and Assistance Service.

Swansea Council - Services for People with a disability inc DFGs
Case Number: 202000012 - Report issued in March 2021

Mrs B complained that, following an Annual Review Meeting on 11 October 2017, the Council failed to communicate effectively and appropriately when her son, Mr W, transitioned from children's to adult's services and failed to adequately prepare for, and manage, his social care when his educational provision ended. She also complained that the Council did not consider her requests for an enhanced rate of Direct Payments and for her to receive financial remuneration for managing her son's care package. Finally, Mrs B complained that the Council did not provide her with respite, despite this being an eligible identified need.

The Ombudsman found that, in the context of uncertainty around whether Mrs B would be able to obtain funding for further education for her son, the Council had recognised the possibility that a contingency plan may be required. However, it failed to take proactive steps to draw one up. He found that there was no record of contact with Mrs B for the 6 months leading up to a crisis point when the education funding ended but no alternative provision had been put in place to meet Mr W's social care needs. He also found that the Council's record keeping was inadequate to enable staff to communicate clearly and consistently with Mrs B about the situation. The Ombudsman upheld these elements of the complaint.

The Ombudsman did not find any evidence of maladministration in the Council's consideration of Mrs B's requests for an enhanced rate of Direct Payments. He also found no evidence that the Council had failed to consider whether Mrs B had any eligible needs arising from her role in managing Mr W's care package. However, he found that the pressure to resolve the issues relating to Mr W's whole care package overshadowed Mrs B's need for respite and led to a breakdown in the relationship between Mrs B and the Council. As a result, Mrs B grew reluctant to engage in further assessments and the Council was unable to establish how the requested respite would be provided and, consequently, it failed to provide Mrs B with appropriate respite to meet her identified need.

The Ombudsman upheld this element of the complaint.

The Council agreed to apologise to Mrs B, advise her clearly of what information it required to calculate appropriate respite and to inform her of how respite will be provided to her, as well as resuming appropriate ongoing assessments of the needs of both Mrs B and Mr W. It agreed to undertake these actions within 1 month. The Council also agreed to take steps to improve its internal record keeping within 3 months. The Council had introduced a programme to review and improve its social work

practices, particularly around transition. It agreed to conduct random sample audits of the completion of Care and Support Plans and the effectiveness of contingency planning in transition, and to draw up an action plan to address any residual shortcomings, within 9 months.

Early Resolution or Voluntary Settlement

Betsi Cadwaladr University Health Board - Continuing care
Case Number: 202002450 - Report issued in February 2021

Mr A complained that an Independent Review Panel ("IRP") arranged by Betsi Cadwaladr University Health Board to determine his late mother's eligibility for NHS Funded Continuing Healthcare ("CHC") was not held in accordance with national guidance.

Having reviewed the available evidence, the Ombudsman was concerned that certain relevant documents were not considered by the IRP. This was not in keeping with the national guidance and was potentially unfair, particularly given that the documents related to a period for which eligibility had been recommended earlier in the process but which the IRP overturned.

In settlement of the complaint, the Health Board agreed to offer Mr A a new IRP, comprised of members who had not been involved in the previous IRP. It also agreed to carry out a fresh review of the available evidence to provide reassurance that all relevant evidence would be taken into account. The Ombudsman considered that this amounted to a reasonable resolution of Mr A's complaint.

Caerphilly County Borough Council - Services for People with a disability inc DFGs
Case Number: 202004658 - Report issued in February 2021

Mr A complained that the Caerphilly Council's assessment of his mother's application for a Disabled Persons Parking Place ("DPPP") was unfair and inconsistent, with other applications with identical context having been approved previously.

The Ombudsman found that his office had previously undertaken an investigation into the Council's handling of DPPP applications, whereby a recommendation was made for the Council to improve its procedure to ensure consistency in its assessment of DPPP applications. Mr A had provided the Council with details of an application that had previously been approved whereby the applicant's circumstances were similar to that of Mr A's mother. The Council said that it was unable to find any record of the application. The Ombudsman found that Mr A's concerns about the consistency of the Council's assessment of DPPP were valid ones.

The Ombudsman contacted the Council and is agreed to:

Within 8 weeks:

- Commission and undertake an independent audit of the Council's DPPP process in order to determine if the assessment process is consistent and applications are being determined in accordance with the Council's DPPP criteria.

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