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Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr

Bridgend County Borough Council



Swyddfeydd Dinesig, Stryd yr Angel, Pen-y-bont, CF31 4WB / Civic Offices, Angel Street, Bridgend, CF31 4WB

*Rydym yn croesawu gohebiaeth yn Gymraeg.
Rhowch wybod i ni os mai Cymraeg yw eich
dewis iaith.*

*We welcome correspondence in Welsh. Please
let us know if your language choice is Welsh.*



Cyfarwyddiaeth y Prif Weithredwr / Chief Executive's Directorate

Deialu uniongyrchol / Direct line /: 01656 643148 /
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Gofynnwch am / Ask for: Mark Anthony Galvin

Ein cyf / Our ref:

Eich cyf / Your ref:

Dyddiad/Date: Wednesday 4 December 2019

Dear Councillor/Lay Member,

STANDARDS COMMITTEE

A meeting of the Standards Committee will be held in the Council Chamber, Civic Offices Angel Street Bridgend CF31 4WB on **Thursday, 12 December 2019 at 14:00**.

AGENDA

1. Apologies for Absence
To receive apologies for absence from Members.
2. Declarations of Interest
To receive declarations of personal and prejudicial interest (if any) from Members/Officers in accordance with the provisions of the Members' Code of Conduct adopted by Council on 1 September 2008.
3. Approval of Minutes 3 - 4
To receive for approval the Minutes of 07/03/2019
4. Local Government and Elections (Wales) Bill 5 - 8
5. Standards Committee Training 9 - 12
6. Ombudsman Annual Letter 2018/19 13 - 22
7. Ombudsman Casebook 23 - 76
8. Urgent Items
To consider any item(s) of business in respect of which notice has been given in accordance with Part 4 (paragraph 4) of the Council Procedure Rules and which the person presiding at the meeting is of the opinion should by reason of special circumstances be transacted at the meeting as a matter of urgency.

Yours faithfully

K Watson

Head of Legal and Regulatory Services

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Councillors:
MC Clarke

Councillors
G Walter

Councillors
P Davies

Lay Members
Mr P Clarke
Mr C Jones OBE
Mr J Baker
Mrs J Kiely

STANDARDS COMMITTEE - THURSDAY, 7 MARCH 2019

MINUTES OF A MEETING OF THE STANDARDS COMMITTEE HELD IN COMMITTEE ROOM 1 - CIVIC OFFICES ANGEL STREET BRIDGEND CF31 4WB ON THURSDAY, 7 MARCH 2019 AT 10:00

Present

Councillor Mr C Jones OBE – Chairperson

MC Clarke

DRW Lewis

Mr J Baker

Apologies for Absence

Mr P Clarke and Mrs J Kiely

Officers:

Andrew Rees

Democratic Services Manager

Kelly Watson

Head of Legal & Regulatory Services

45. DECLARATIONS OF INTEREST

None.

46. APPROVAL OF MINUTES

RESOLVED: That the minutes of the meeting of the Standards Committee of 10 October 2018 be approved as a true and accurate record.

47. WLGA SOCIAL MEDIA GUIDANCE FOR COUNCILLORS

The Monitoring Officer presented the guidance produced by the Welsh Local Government Association (WLGA) on the use of social media by Councillors.

The Monitoring Officer informed the Committee that the WLGA recognises that social media plays an increasingly important role in politics and has prepared a guide for Elected Members in relation to its use. She stated that the purpose of the guidance is to enable Members to benefit from the use of social media whilst minimising the associated risks such as reputational damage and breaching the code of conduct. Guidance has also been produced to advise Members on how to manage or report online abuse or harassment.

RESOLVED: That the Committee noted the WLGA guidance.

48. OMBUDSMAN ANNUAL LETTER

The Monitoring Officer presented the Committee with the Ombudsman's Annual Letter for 2017/18, which details the performance of the authority against an average for local authorities in Wales and with the wider public sector report, which contains statistical information about complaints considered in the year.

The Monitoring Officer reported that the number of complaints received by the Ombudsman in relation to this Council had decreased during this period by 10% from 44 to 40, with there being no public interest reports against the Council and only 1 case taken forward for investigation. Complaints regarding Children's Social Services had halved from 12 to 6 in the past year, however complaints against Environment and Environment Health had increased from 3 to 9.

RESOLVED: That the Committee noted the report.

49. OMBUDSMAN CASEBOOK AND CODE OF CONDUCT CASEBOOK

The Monitoring Officer reported on a summary of cases which had been undertaken by the Ombudsman's Office for July to October 2018. The Code of Conduct Casebook is published on a quarterly basis and contains the summaries of all reports issued as well as a selection of summaries relating to quick fixes and voluntary settlements. The Code of Conduct Casebook contains the summaries of those cases for which the hearings by the Standards Committee of Adjudication Panel for Wales have been concluded and where the outcome of the hearing is known for the period October to December 2018.

The Monitoring Officer informed the Committee that the Ombudsman attends quarterly meetings with the All Wales Monitoring Officer's Group and also attends a number of public facing events to promote the work of the Ombudsman's office.

RESOLVED: That the Committee noted the report.

50. URGENT ITEMS

None

51. EXCLUSION OF THE PUBLIC

RESOLVED: That under Section 100A (4) of the Local Government Act 1972 as amended by the Local Government (Access to Information) (Variation) (Wales) Order 2007, the public be excluded from the meeting during consideration of the following items of business as they contained exempt information as defined in Paragraph 12 of Part 4 and/or Paragraph 21 of Part 5 of Schedule 12A of the Act.

Following the application of the public interest test it was resolved that pursuant to the Act referred to above, to consider the following items in private, with the public excluded from the meeting, as it was considered that in all the circumstances relating to the items, the public interest in maintaining the exemption outweighed the public interest in disclosing the information, because the information would be prejudicial to the applicants so mentioned.

52. APPROVAL OF EXEMPT MINUTES

RESOLVED: That the minutes of the meeting of the 10/10/2018 be approved as a true and accurate record.

The meeting closed at 10:55

BRIDGEND COUNTY BOROUGH COUNCIL
REPORT TO THE STANDARDS COMMITTEE
12 DECEMBER 2019

REPORT OF THE MONITORING OFFICER
LOCAL GOVERNMENT AND ELECTIONS (WALES) BILL

1. Purpose of Report

- 1.1 To provide Members with the key proposals in the Local Government and Elections (Wales) Bill.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

- 2.1 Standards are an implicit requirement in the successful achievement of the corporate priorities.
- 2.2 This report assists in the achievement of all the following corporate priority/priorities:

Smarter use of resources – ensuring that all its resources (financial, physical, human and technological) are used as effectively and efficiently as possible and support the development of resources throughout the community that can help deliver the Council's priorities.

3. Background

- 3.1 The Local Government and Elections (Wales) Bill was presented in November 2019 to the National Assembly for Wales. It will reform and strengthen local government and improve electoral arrangements.

4. Current situation / proposal

- 4.1 The key proposals in the Bill are outlined at paragraphs 4.2 to 4.6 for information.

4.2 Local Government Electoral Arrangements

- 4.2.1 The voting age for local government elections will be lowered from 18 to 16 and the right to stand and vote in local government elections will be extended to qualifying foreign citizens residents in Wales.

- 4.2.2 Local authorities and community councils will be put on a permanent five year electoral cycle, powers will be given to the Welsh Government to establish an all Wales digital electoral register and pilots of new ways to hold local elections will be allowed (i.e all postal voting, new voting hours, electronic voting, electronic counting).

- 4.3 Disqualification criteria to stand as a councillor

4.3.1 People who have been declared bankrupt, are registered sex offenders, have served a prison (suspended or not) sentence of 3 months or more will be disqualified.

4.3.2 Council staff will be allowed to stand in elections to their employer local authority but will be required to resign if elected.

4.4 Governance Arrangements

4.4.1 The Bill will introduce a general power of competence for local authorities and eligible community councils, giving the power to act in their respective community's best interests, generate efficiencies and secure value for money.

4.4.2 Local authorities will still need to appoint a Chief Executive but must publish arrangements for managing their performance. The Bill introduces job sharing for Cabinet level positions and places a requirement on councils to have provision for maternity leave for councillors.

4.4.3 Standard Committees will be required to publish an Annual Report, while community councils will need to draft and publish a training plan for councillors and staff.

4.5 Mergers

4.5.1 There will be provision for regional working by more than one local authority through corporate joint committees. It also gives the Welsh Government the power to intervene or order one local authority to assist another one if it is believed a council isn't meeting performance requirements (based on self-assessment and peer review).

4.5.2 Any mergers will be wholly voluntary. Two or more local authorities can apply to Welsh Government with a merger application. The Bill sets out the formal public consultation process and regulations required to create a merged local authority. Councils can also request to be abolished.

4.6 Public engagement

4.6.1 Local authorities will be required to publish a public participation strategy. There will also be a duty placed on local authorities to encourage local people to participate in local government.

4.6.2 Local authorities will need to introduce public petition schemes, webcast all public meetings (subject to regulations) and make arrangements for remote attendance by councillors. These provisions will not apply to community councils.

4.6.3 Community Councils will be required to allow members of the public to make representations during meetings and publish annual reports at the end of each financial year.

5. Effect upon Policy Framework & Procedure Rules

5.1 None.

6. Equality Impact Assessment

6.1 None.

7. Wellbeing of Future Generations (Wales) Act 2015 Implications

7.1 The well-being goals identified in the Act were considered in the preparation of this report. As the report is for noting only, it is considered that there will be no significant or unacceptable impacts upon the achievement of well-being goals/objectives as a result of this report.

8. Financial Implications

8.1 It is unclear at this stage how much the Local Government and Elections (Wales) Bill will cost the Authority.

8.2 The total cost of the Bill's provision is expected to be around £17.2 million spread over 10 years. Most of this will fall on Welsh Government, with around £3 million falling on local government.

9. Recommendation

9.1 Members are recommended to note the report.

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Background Documents

None

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BRIDGEND COUNTY BOROUGH COUNCIL
REPORT TO THE STANDARDS COMMITTEE
12 DECEMBER 2019
REPORT OF THE MONITORING OFFICER
STANDARDS COMMITTEE TRAINING

1. Purpose of Report

1.1 To consider appropriate training programmes for the Committee.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 Standards are an implicit requirement in the successful achievement of the corporate priorities.

2.2 This report assists in the achievement of the following corporate priority/priorities:

Smarter use of resources – ensuring that all its resources (financial, physical, human and technological) are used as effectively and efficiently as possible and support the development of resources throughout the community that can help deliver the Council's priorities.

3. Background

3.1 It is essential that Members of the Standards Committee are adequately trained if they are to effectively and efficiently carry out their roles.

4. Current situation / proposal

4.1 All members of the Committee have undertaken a comprehensive induction programme which included training on the Code of Conduct.

4.2 At the 2018 Standards Conference Wales, held in the University of Wales, Members were able to participate in a variety of workshops on relevant topics such as; sharing best practice in the role of the Standards Committee, personal and prejudicial interests and dispensations; the practical aspects of holding a Standards Hearing and Social Media and Bullying. The Conference was also addressed by Nick Bennett, the Public Services Ombudsman for Wales and the President of the Adjudication Panel for Wales on current issues relevant to their offices.

4.3 Consideration will be given to joint training sessions with other Standards Committees across Wales and for Members to observe other Standard Committees in order to engage, share good practices and experiences. It was recognised in the 2018 Conference that there is a need to incorporate good practices of other Standards Committees across Wales.

4.4 Arrangements are being made for a training session on Chairing meetings to be held. This may focus on the Independent Members who are required to chair the meeting of the Standards Committee and it is hoped that this will take place in the New Year.

4.5 No training has been provided in relation to the procedure that the Committee will follow where it is required to make decisions about the conduct of Councillors following investigations by the Public Services Ombudsman for Wales or the Council's Monitoring Officer. It is anticipated that this will be arranged at such time as it becomes necessary.

5. Effect upon Policy Framework & Procedure Rules

5.1 None.

6. Equality Impact Assessment

6.1 None.

7. Wellbeing of Future Generations (Wales) Act 2015 Implications

7.1 The well-being goals identified in the Act were considered in the preparation of this report. As the report is for noting only, it is considered that there will be no significant or unacceptable impacts upon the achievement of well-being goals/objectives as a result of this report.

8. Financial Implications

8.1 Where appropriate, training will be delivered or supported using internal resources, but where necessary external providers will be utilised with the costs met using existing resources.

9. Recommendation

9.1 Members are requested to note the report and consider training requirements they may have.

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Background Documents
None

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BRIDGEND COUNTY BOROUGH COUNCIL
REPORT TO THE STANDARDS COMMITTEE
12 DECEMBER 2019
REPORT OF THE MONITORING OFFICER
OMBUDSMAN ANNUAL LETTER 2018/19

1. Purpose of Report

1.1 To provide Members with a copy of the Ombudsman's Annual Letter 2018/19.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 Standards are an implicit requirement in the successful implementation of the corporate priorities.

2.2 This report assists in the achievement of the following corporate priority/priorities:

- Smarter use of resources – ensuring that all its resources (financial, physical, human and technological) are used as effectively and efficiently as possible and support the development of resources throughout the community that can help deliver the Council's priorities.

3. Background

3.1 The Public Service Ombudsman for Wales (PSOW) is independent of all government bodies and has legal powers to investigate complaints about public services and independent care providers in Wales. They also investigate complaints that Members of local government bodies have breached their authority's Code of Conduct.

3.2 The PSOW reports annually on the number of complaints against public bodies received by its office.

3.3 The Complaints Officer is the Contact Officer for the PSOW and the Monitoring Officer is responsible for liaising with the PSOW regarding Member Code of Conduct complaints.

4. Current situation/proposal

4.1 **Appendix A** provides the Ombudsman's Annual Letter for 2018-2019.

4.2 The number of complaints against the Authority decreased in the period 2018-2019 from 40 in 2017-18 to 33 in 2018-19. This is against a local authority average adjusted for population distribution of 41. None of the complaints against the Authority proceeded to investigation. The PSOW intervened in 6 of these cases.

Children's Services attracted the largest number of complaints at 7 and Roads and Transport the least with 1.

- 4.3 One Code of Conduct complaint against the Authority's Councillors was received by the Ombudsman's Office in this period and was closed after initial consideration. 17 Code of Conduct complaints were received against Town and Community Councils in Bridgend County and all were closed after initial consideration.

5. Effect upon Policy Framework & Procedure Rules

- 5.1 None.

6. Equality Impact Assessment

- 6.1 There are no equality issues arising from this report.

7. Wellbeing of Future Generations (Wales) Act 2015 Implications

- 7.1 The well-being goals identified in the Act were considered in the preparation of this report. As the report is for noting only, it is considered that there will be no significant or unacceptable impacts upon the achievement of well-being goals/objectives as a result of this report.

8. Financial Implications

- 8.1 The PSOW has the legal power to require authorities to make payments to complainants where they have suffered financial loss or in compensation for distress and inconvenience.

9. Recommendation

- 9.1 The Committee is recommended to note the report.

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Background Documents


None

Our ref: NB

Ask for: Communications

 01656 641150

Date: 7 August 2019

 communications
@ombudsman-wales.org.uk

Councillor Huw David
Council Leader
Bridgend County Borough Council

By Email Only
cllr.huw.david@bridgend.gov.uk

Dear Councillor Huw David

Annual Letter 2018/19

I am pleased to provide you with the Annual letter (2018/19) for Bridgend County Borough Council. This year I am publishing my Annual Letters as part of my Annual Report and Accounts. I hope the Council finds this helpful and I trust this will enable it to review its own complaint handling performance in the context of other public bodies performing similar functions across Wales.

Whilst overall the number of complaints received relating to local authorities across Wales increased from 794 to 912, I am pleased that local authorities continue to work with my office to resolve many of these complaints at an early stage. This provides complainants with appropriate and timely remedies avoiding the need for my office to fully investigate complaints.

A summary of the complaints of maladministration/service failure received relating to the Council is attached.

Also attached is a summary of the Code of Conduct complaints relating to members of the Council and the Town & Community Councils in your area.

Page 1 of 7

The Public Services Ombudsman (Wales) Act 2019 has now been introduced. I am delighted that the Assembly has approved this legislation giving the office new powers aimed at:

- Improving access to my office
- Providing a seamless mechanism for complaint handling when a patient's NHS care is inextricably linked with private healthcare
- Allowing me to undertake own initiative investigations when required in the public interest
- Ensuring that complaints data from across Wales may be used to drive improvement in public services for citizens in Wales.

I am very much looking forward to implementing these new powers over the coming year.

Action for the Council to take:

- Present my Annual Letter to the Cabinet to assist Members in their scrutiny of the Council's performance
- Work to reduce the number of cases which require intervention by my office
- Inform me of the outcome of the Council's considerations and proposed actions on the above matters by **31 October 2019**.

This correspondence is copied to the Chief Executive of your Council and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely



Nick Bennett
Public Services Ombudsman for Wales

CC: Mark Shephard, Interim Chief Executive
Charlotte Branford, Contact Officer

Factsheet**A. Complaints Received and Investigated with Local Authority average adjusted for population distribution**

Local Authority	Complaints Received	Average	Complaints Investigated	Average
Bridgend County Borough Council 2018/19	33	41	0	1
Bridgend County Borough Council 2017/18	40	36	1	1
Blaenau Gwent County Borough Council	8	20	0	0
Caerphilly County Borough Council	65	51	1	1
Cardiff Council	115	103	0	2
Carmarthenshire County Council	49	53	1	1
Ceredigion County Council	23	21	0	0
City and County of Swansea	83	70	0	2
Conwy County Borough Council	41	33	2	1
Denbighshire County Council	26	27	1	1
Flintshire County Council	50	44	2	1
Gwynedd Council	32	35	2	1
Isle of Anglesey County Council	31	20	2	0
Merthyr Tydfil County Borough Council	15	17	0	0
Monmouthshire County Council	20	27	0	1
Neath Port Talbot County Borough Council	38	40	1	1
Newport City Council	38	43	0	1
Pembrokeshire County Council	35	35	0	1
Powys County Council	67	38	4	1
Rhondda Cynon Taf County Borough Council	36	68	0	2
Torfaen County Borough Council	12	26	1	1
Vale of Glamorgan Council	24	37	0	1
Wrexham County Borough Council	45	38	3	1
Grand Total	886		20	

B. Complaints Received by Subject

Bridgend	Complaints Received
Adult Social Services	2
Children Social Services	7
Complaints Handling	3
Education	2
Environment and Environmental Health	6
Finance and Taxation	2
Housing	2
Planning and Building Control	3
Roads and Transport	1
Various Other	5

C. Comparison of complaint outcomes with average outcomes for Local Authorities, adjusted for population distribution

Local Authority	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution / Voluntary settlement	Discontinued	Other Report - Not upheld	Other Report - Upheld in whole or in part	Public Interest Reports
2018/19								
Bridgend County	8	12	11	5	-	-	-	-
Bridgend County (adjusted)	7	13	14	5	0	1	1	0
2017/18								
Bridgend County	8	10	16	5	-	-	-	-
Bridgend County (adjusted)	6	10	13	5	0	1	1	0

D. Number of cases with PSOW intervention

Local Authority	No. of complaints with PSOW intervention	Total number of closed complaints	% of complaints with PSOW intervention
Bridgend County Borough Council 2018/19	6	36	17%
Bridgend County Borough Council 2017/18	5	39	13%
Blaenau Gwent County Borough Council	2	7	29%
Caerphilly County Borough Council	8	68	12%
Cardiff Council	19	110	17%
Carmarthenshire County Council	4	48	8%
Ceredigion County Council	5	24	21%
City and County Swansea	10	80	13%
Conwy County Borough Council	5	39	13%
Denbighshire County Council	4	30	13%
Flintshire County Council	16	56	29%
Gwynedd Council	6	35	17%
Isle of Anglesey County Council	5	31	16%
Merthyr Tydfil County Borough Council	0	14	0%
Monmouthshire County Council	0	23	0%
Neath Port Talbot County Borough Council	4	40	10%
Newport City Council	7	43	16%
Pembrokeshire County Council	6	33	18%
Powys County Council	11	64	17%
Rhondda Cynon Taf County Borough Council	4	34	12%
Torfaen County Borough Council	1	12	8%
Vale of Glamorgan Council	7	30	23%
Wrexham County Borough Council	8	43	19%

E. Code of Conduct Complaints Closed

Local Authority	Closed after initial consideration	Discontinued	No evidence of breach	No action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total
2018/19								
Bridgend	1	-	-	-	-	-	-	1
2017/18								
Bridgend	3	-	-	1	-	-	-	4

F. Town/Community council Code of Conduct Complaints

Town/Community Council	Closed after initial consideration	Discontinued	No evidence of breach	No Action necessary	Refer to Standards Committee	Refer to Adjudication Panel	Withdrawn	Total
Brackla CC	2	-	-	-	-	-	-	2
Bridgend TC	4	-	-	-	-	-	-	4
Garw Valley CC	1	-	-	-	-	-	-	1
Maesteg TC	1	-	-	-	-	-	-	1
Pencoed TC	4	-	-	-	-	-	-	1
Porthcawl TC	3	-	-	-	-	-	-	3
Ynysawdre CC	2	-	-	-	-	-	-	2

Appendix

Explanatory Notes

Section A compares the number of complaints against the Local Authority which were received and investigated by my office during 2018/19, with the Local Authority average (adjusted for population distribution) during the same period.

Section B provides a breakdown of the number of complaints about the Local Authority which were received by my office during 2018/19. The figures are broken down into subject categories.

Section C compares the complaint outcomes for the Local Authority during 2018/19, with the average outcome (adjusted for population distribution) during the same period.

Section D provides the numbers and percentages of cases received by our office in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Section E provides a breakdown of all Code of Conduct complaint outcomes against Councillors during 2018/19.

Section F provides a breakdown of all Code of Conduct complaint outcomes against town or community councils.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk

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BRIDGEND COUNTY BOROUGH COUNCIL
REPORT TO THE STANDARDS COMMITTEE
12 DECEMBER 2019
REPORT OF THE MONITORING OFFICER
OMBUDSMAN CASEBOOK

1. Purpose of Report

- 1.1 To provide Members with a summary of cases that have been undertaken by the Ombudsman's Office.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

- 2.1 Standards are an implicit requirement in the successful achievement of the corporate priorities.
- 2.2 This report assists in the achievement of the following corporate priority/priorities:

Smarter use of resources – ensuring that all its resources (financial, physical, human and technological) are used as effectively and efficiently as possible and support the development of resources throughout the community that can help deliver the Council's priorities.

3. Background

- 3.1 The Ombudsman's Casebook is published on a quarterly basis and contains the summaries of all reports issued during the quarter, as well as a selection of summaries relating to quick fixes and voluntary settlements.

4. Current situation / proposal

- 4.1 The Casebook for April – June 2019 is attached at **Appendix 1**.

5. Effect upon Policy Framework & Procedure Rules

- 5.1 None.

6. Equality Impact Assessment

- 6.1 None.

7. Wellbeing of Future Generations (Wales) Act 2015 Implications

- 7.1 The well-being goals identified in the Act were considered in the preparation of this report. As the report is for noting only, it is considered that there will be no

significant or unacceptable impacts upon the achievement of well-being goals/objectives as a result of this report.

8. Financial Implications

8.1 None.

9. Recommendation

9.1 The Committee is recommended to note the report.

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Background Documents

None

The Ombudsman's Casebook

Issue 37 April – June 2019

News

Consultation is now open

Consultation is now open on the principles and procedures relating to the new powers created by the Public Services Ombudsman (Wales) Act 2019, which came into force on July 23rd, 2019. It will be easier to complain about public services with a range of new powers designed to widen access to justice and reduce poor service delivery. The Ombudsman now accepts verbal complaints, has the power to conduct 'Own Initiative' investigations and the new Act has created the Complaints Standards Authority for Wales.



Public Services Ombudsman for Wales, Nick Bennett, said:

"Five years after I came into office, this is a proud moment for me, and for Wales. The new powers come into force at a critical time for my office, and for public services in general".

You can participate in the Consultation by sending comments to communications@ombudsman.wales. The Consultation closes on 20 September 2019.

The Ombudsman's Casebook

Issue 37 April – June 2019

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Health

Upheld

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

[Case Number: 201800838 – Report issued in April 2019](#)

Mr & Mrs C complained about the care given to Mrs C during her stay in hospital for the birth of their daughter, Baby K, and the subsequent care of Baby K. In particular, they complained about inadequate information provided to them about the induction process and failings in communication, inappropriate behaviour of professionals and inadequate record-keeping.

The Ombudsman found Mr & Mrs C had not been given adequate information as there was no record of what they had been given. He found that the Health Board had not appropriately investigated Mr & Mrs C's allegations, in particular about the behaviour of a neonatal doctor, but noted it had now referred the concerns to the local Safeguarding Hub. Record-keeping was clearly inadequate in several areas; indeed, the Health Board was unable to produce any records for Baby K for the relevant period.

The Ombudsman made recommendations for an apology and a redress payment, as well as for informing Mr & Mrs C of the outcome of the Safeguarding Hub's investigation.

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

[Case Number: 201708130 – Report issued in April 2019](#)

Mrs A complained about the care and treatment provided to her late father, (Mr B), at Royal Gwent Hospital and Ysbyty Ystrad Fawr, following his admission after suffering a stroke at home. Her concerns included shortcomings in her father's nursing care as well as the Health Board's handling of her complaint. Additionally, Mrs A complained about the delay in the Welsh Ambulance Services NHS Trust ("WAST") despatching an ambulance to her father when her call was not correctly prioritised.

Overall the Ombudsman's investigation found that the medical care and treatment provided to Mr B was reasonable and appropriate and therefore did not uphold Mrs A's complaint.

In relation to nursing care the Ombudsman's investigation found that there were shortcomings in meeting Mr B's fluid and nutritional needs and record keeping and to a limited extent upheld this aspect of Mrs A's complaint. The investigation upheld Mrs A's concerns about complaint handling to the extent that the Health Board's investigation had not been sufficiently robust. Amongst the recommendations the Ombudsman made were that the Health Board should apologise to Mrs A for the additional failings his investigation had identified and make a redress payment of £250 in recognition of the effect that shortcomings in complaint handling would have had on Mrs A.

Finally in relation to Mrs A's concerns about WAST the Ombudsman found that her call had been appropriately categorised and whilst there was a delay in the ambulance arriving it was not unreasonable. Therefore, Mrs A's complaint was not upheld.

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

[Case Number: 201802138 – Report issued in April 2019](#)

Ms K complained about surgery carried out in October 2017, which she said had damaged the outward appearance of her nose. Ms K also complained that she was not properly warned that the surgery might change the appearance of her nose. Ms K said that she was very upset and distressed by the outcome of her surgery, which left her depressed and unwilling to go out in public.

The Ombudsman found that the evidence suggested the operation was carried out to an appropriate standard. Whilst unfortunate, the complication Ms K suffered was a known risk of the procedure. The Ombudsman did not uphold this part of the complaint. Turning to the consent process, the Ombudsman found that the initial discussion about potential risks at an outpatient appointment in March 2017 was appropriate and Ms K was given a leaflet to take away which included the relevant risks. However, there was no record of any discussion about potential complications on the day of the operation itself and Ms K's consent was not confirmed on the form. This was a lost opportunity for Ms K to weigh up the options and reach an informed decision about whether to go ahead. The Ombudsman upheld the complaint to that extent only. He recommended that the Health Board apologise, pay Ms K £500 to reflect the loss of opportunity and remind its ENT surgeons of the importance of confirming consent on the day of surgery and recording it on the form when the original consent was given some time ago.

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

[Case Number: 201803055 – Report issued in April 2019](#)

Ms R complained about the care she received from Betsi Cadwaladr University Health Board ("the Health Board") in relation to the assessment and treatment of the progression of her radiation enteritis (inflammation of the intestines which occurs after radiation therapy and causes various symptoms, including diarrhoea, nausea, vomiting and stomach cramps).

The Ombudsman accepted that it was not unreasonable for the Health Board to decline to undertake any further investigations or intervene because Ms R's care was already being overseen by another Health Board, at Ms R's request. Furthermore, the information available to the Health Board had not indicated any escalation in Ms R's symptoms since the last time she had been assessed. However, the Ombudsman found that Ms R should have been referred to a dietician for advice on managing her symptoms.

The Ombudsman recommended that, within one month of the date of his report, the Health Board should apologise to Ms R and offer to make a referral to a dietician if Ms R had not already been referred to one by the other Health Board.

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

[Case Number: 201707660 – Report issued in April 2019](#)

Mrs D complained to the Ombudsman about the circumstances surrounding the death of her mother, Mrs M, who suffered a cardiac arrest while an inpatient on the Assessment Unit ('the Unit') at Singleton Hospital on 31 March 2017. Mrs D complained that:

- a) Nurses failed to notice that Mrs M had collapsed and fallen to the floor from a bedside chair.
- b) The Health Board subsequently attempted to 'cover-up' what happened by altering its account of the timeframe and manner in which Mrs M was found on the floor by nurses.
- c) Shortly after her mother's death, clinicians contacted the family and advised them to urgently attend the Unit. However, they were not told over the telephone that Mrs M had passed away.

Mrs D also complained that:

- d) There were failings in elements of the nursing care that Mrs M received on the Unit prior to her death.
- e) Mrs M's history of cardiac problems were not taken into account in the assessment and treatment of her condition.
- f) The Health Board's handling of the family's complaints about these matters was deficient and protracted.

The Ombudsman found that there were concerning failings in aspects of the nursing care that Mrs M received (particularly in relation to record-keeping) and that there were failings in the Health Board's internal investigation of the complaint. The Ombudsman did not uphold any of Mrs D's other complaints. Whilst it was acknowledged that the Health Board revised its account of the circumstances of Mrs M's

death (as new information came to light) there was no evidence of any intention by clinicians to misinform or cover-up the events in question.

The Ombudsman recommended that the Health Board provides Mrs D with a fulsome apology and a £250 payment in recognition of the identified complaint-handling failings. The Ombudsman also recommended that the Health Board prepares an action plan which demonstrates that the identified nursing care and nursing record-keeping failings are disseminated and reflected upon by nurses on the Unit. Finally the Ombudsman recommended that the complaint-handling/complaint investigation failings are brought to the attention of the Health Board's Concerns Team.

The Health Board agreed to implement these recommendations.

[HMT Sancta Maria Hospital - Clinical treatment in hospital](#) [Case Number: 201802896 & 201801351 – Report issued in May 2019](#)

Ms A complained about an operation to treat a long-term skin condition which was carried out at a Private Hospital but paid for by the NHS. Unfortunately, Ms A's stitches burst shortly after the operation took place, prolonging her recovery. Ms A was particularly concerned about the discharge and post-operative aftercare arrangements.

The Ombudsman concluded that the standard of care was broadly reasonable, but was concerned about some aspects of the discharge arrangements from the Private Hospital, particularly in relation to the information Ms A was given at the time. The Ombudsman upheld the complaint against the Private Hospital to that extent only. He did not uphold the complaints against the Health Board. The Ombudsman recommended that the Private Hospital apologise to Ms A and review its discharge arrangements, particularly the information given to patients.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201801440 – Report issued in May 2019](#)

Mrs N complained about the care her late mother, Mrs P, received while an inpatient in January/February 2018. The complaint concerned a range of issues, including delay in diagnosis of ischaemic colitis, medication issues (including pain relief), the failure to act in Mrs P's best interests and to treat her with dignity and respect.

The Ombudsman partly upheld Mrs N's complaint. He found that Mrs P's symptoms did not suggest ischaemic colitis and she was never diagnosed with this. The nursing care she received was appropriate, her deterioration was recognised and escalated, and decisions were made in her best interests. The necessary medication was administered in an appropriate way. Although there was inadequate assessment and planning for the management of Mrs P's pain, meaning that it was reactive rather than proactive, there was no evidence that requests for pain relief were not responded to appropriately, or that pain relief given was not effective.

The Ombudsman recommended the Health Board apologise to Mrs N for the failings identified, and remind staff of the importance of the accurate assessment and recording of pain, and proactive planning for its management. The Health Board agreed to implement the recommendations.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) [Case Number: 201800914 – Report issued in May 2019](#)

Mr A complained about the care and treatment provided by Betsi Cadwaladr University Health Board ("the Health Board") to his late wife Mrs A, concerning respiratory (breathing system), oncology (cancer) and nursing care, and the way it handled his complaint.

The Ombudsman found the Health Board failed to address Mr A's concerns regarding an admission and discharge on 22 June 2017 and discharged Mrs A inappropriately. The Ombudsman also found the Health

Board failed to provide Mr and Mrs A with adequate information concerning treatment and prognosis which caused anxiety and distress and these elements of the complaint were upheld. The Ombudsman found the overall care and treatment provided to Mrs A was reasonable and in line with relevant guidance, therefore this aspect of Mr A's complaint was not upheld.

The Health Board agreed to explain to Mr A why it did not fully address his concerns and to apologise for the failings identified. It also agreed to share the report with relevant staff for critical reflection.

Castle Gate Medical Practice - Clinical treatment outside hospital

Case Number: 201804313 – Report issued in May 2019

Mrs A complained about the care and management she had received regarding an undiagnosed leg/hip pain from a doctor ("the GP") at the Practice since 2013. She wanted to know if the GP had missed opportunities to diagnose her condition sooner. Mrs A also complained about the Practice's handling of her complaint. The Ombudsman's investigation concluded that up until 5 October 2016 Mrs A's care and management was reasonable and appropriate. He found that there was a missed opportunity by the GP to examine Mrs A on 5 October which might have prompted an X-ray referral with the possibility that a diagnosis of osteoarthritis might have been made sooner than it was with a possible resulting change in her clinical management. To that limited extent he upheld this aspect of Mrs A's complaint.

In relation to the Practice's handling of Mrs A's complaint, the Ombudsman concluded that given the circumstances it would have been appropriate for the complaint response to have been provided by the senior partner. This would have demonstrated there had been internal scrutiny of the complaint and accorded with the Ombudsman's guidance on good administration. To that extent Mrs A's complaint was upheld. The Ombudsman recommended that the Senior Partner apologise to Mrs A for the failings identified by the investigation. The Practice was asked to reflect on the lessons to be learnt from Mrs A's complaint including from a complaint handling perspective.

Abertawe Bro Morgannwg University Health Board - Patient list issues

Case Number: 201802233 – Report issued in May 2019

Mr A complained that the delay in the Health Board carrying out his wife's gallbladder removal surgery resulted in her having to pay for the surgery to be carried out privately. Mr A said that appropriate information about waiting times were not given to them. Additionally, he said that during his wife's initial admission there was a lack of urgency when his wife fell and hit her face. Mr A said that his wife was not fully checked over for any potential head injuries. Mr A also had concerns about the Health Board's handling of his complaint.

The Ombudsman's investigation concluded that the failure to offer Mrs A treatment within the timescale allowed by the waiting time rules was, on the face of it, a service failure. However, he was satisfied that the delay had not caused a significant injustice or hardship to Mrs A and therefore this aspect of Mr A's complaint was not upheld.

The Ombudsman found no evidence of the Health Board having written to Mrs A following its decision to put her on the surgical waiting list. This was despite clear guidance in the waiting list rules about keeping patients informed about the waiting list process. The Ombudsman expressed disappointment that this administrative failing was still occurring despite previous recommendations in this area. He upheld this aspect of Mr A's complaint.

In relation to Mr A's concern about his wife's fall, the Ombudsman's investigation found that Mrs A was appropriately reviewed by a doctor to rule out any serious injuries from the fall. However, he considered the lack of urgency in attending to Mrs A represented a shortcoming in her care which would have added to her distress. Therefore to this extent only he upheld this part of Mr A's complaint.

In relation to Mr A's complaint about the Health Board's handling of his complaint, the Ombudsman noted

that the Health Board had acknowledged there had been shortcomings and had offered to pay a redress payment of £250 to reflect this.

Amongst the recommendations made were that the Health Board should apologise to Mr and Mrs A for the failings identified by the investigation and provide information to the Ombudsman concerning its management of the waiting list.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201801761 – Report issued in May 2019](#)

Mr A's complaint centred around him being administered an anti-psychotic medication - Clopixol depot injection. He said that the dose prescribed was too high and he had been advised by the manufacturer that he should not be on this medication. Mr A said that the medication was making him ill. Mr A also complained about the Health Board's delay in responding to his complaint.

The Ombudsman's investigation found that clinically the Clopixol injection that was being administered to Mr A was needed to effectively treat his condition. The Ombudsman was satisfied that the dose was in keeping with recommended dosage levels and therefore did not uphold Mr A's complaint.

Administratively, the Ombudsman did identify some shortcomings around record keeping which the Health Board's complaint response had not identified and reminded the Health Board of the need to ensure that discussions with patients about their medication were documented in their clinical records. Additionally, whilst the Ombudsman recognised that some delay in complaint handling was caused as a result of the Health Board trying to arrange a meeting with Mr A, it was also evident that there were periods of prolonged and unexplained delays on the part of the Health Board. To that extent this aspect of Mr A's complaint was upheld and the Health Board was asked to apologise to Mr A for the delay in complaint handling and in recognition of this make a payment to him of £250.

[Cardiff and Vale University Health Board - Clinical treatment in hospital](#) [Case Number: 201801472 – Report issued in May 2019](#)

Miss A complained about the care and management she received following a referral for an endoscopy at the University Hospital of Wales ("the Hospital"). Miss A specifically complained about a delay in a barium meal investigation being undertaken. She also complained that there was a failure to ensure that the test for her upper gastrointestinal ("UGI") symptoms was properly undertaken in July 2016 which led to her needing further tests in October 2017. She said she had also been discharged before being given the results and a treatment plan. Finally, Miss A said that there was a failure to appropriately resolve her complaint.

The Ombudsman's investigation concluded that broadly Miss A's clinical care and management was reasonable. However, he did find an unreasonable delay in referring Miss A for a barium meal investigation which prolonged her pain and distress, and caused her injustice. He therefore upheld this aspect of Miss A's complaint.

In relation to Miss A's concerns about the UGI tests not being properly undertaken the investigation found that it was undertaken in two stages instead of one which would have caused inconvenience to Miss A. However the Ombudsman was satisfied that the UGI tests/investigations were carried out appropriately and the results explained to Miss A. He therefore did not uphold this aspect of Miss A's complaint. Administratively, the Ombudsman's investigation concluded that the Health Board's investigation had failed to identify that the root cause of Miss A's complaint was her UGI symptoms and the delay with the barium meal referral. In view of this shortcoming in complaint handling this aspect of Miss A's complaint was upheld.

[Aneurin Bevan University Health Board – Other](#) [Case Number: 201801418 – Report issued in May 2019](#)

Mr A complained about the care provided to his late father, Mr Y, prior to his sad death on 3 June 2017. Mr A said that it was inappropriate for Mr Y to have been discharged from hospital on 2 June and that there had been a failure by hospital staff to effectively communicate with the family about his clinical condition.

The Ombudsman found that it was inappropriate for Mr Y to have been discharged home as he and his family did not have full knowledge and understanding of his clinical condition and prognosis. He found that Mr Y would have benefitted from end of life care at a hospice or a nursing home for terminal care, or the provision of services by a hospice at home.

The Ombudsman found that the Health Board had already acknowledged that Mr A and his family were not included in discussions about Mr Y's care and had taken action to ensure that, in future, the patient and family members are involved in the discharge process and relevant information is shared with them. He found that the lack of communication meant that Mr Y's family were denied the opportunity to be involved in making choices about his discharge and were ill-prepared to cope with Mr Y's deteriorating health at home. The Ombudsman determined that these failings represented an injustice to Mr A and his family as they were left with the distress and trauma of seeing Mr Y's condition deteriorate immediately upon his discharge home and had to endure a further emergency hospital admission. The Ombudsman upheld both complaints and recommended that the Health Board should apologise to Mr A, provide him with financial redress of £1000 and discuss the contents of the investigation report with relevant staff who were involved with the discharge planning of Mr Y.

[Aneurin Bevan University Health Board – Other](#) [Case Number: 201707980 – Report issued in May 2019](#)

Mrs A complained about the mental health treatment and care provided by the Health Board for her late mother, Mrs B. Mrs A said that the Health Board failed to meet Mrs B's clinical needs and unreasonably delayed providing her with appropriate care and support. She also said that the Health Board failed to listen to or act on the family's concerns about Mrs B's mental health.

The Ombudsman found that Mrs B received appropriate assessments, medication and ongoing support and there was no evidence that her care was unreasonably delayed. Although the Ombudsman was satisfied that the Health Board had responded appropriately to the family's concerns about Mrs B's deteriorating mental health and behaviours, there were some examples of poor communication with the family who were left with the impression that they were being ignored. The Ombudsman did not find that this failing had any impact on Mrs B's care.

The Health Board agreed to apologise to Mrs A and to share the Ombudsman's findings with relevant staff so that lessons about the impact of poor communication are learned from the complaint.

[Aneurin Bevan University Health Board - Clinical treatment in hospital](#) [Case Number: 201805378 – Report issued in May 2019](#)

Ms F complained that Aneurin Bevan University Health Board ("the Health Board") failed to reasonably respond to a Case Study, which was submitted to the Health Board in January **2018** and outlined the experiences she and her partner, Mr M, had while he was in hospital the previous year. Ms F also raised a formal complaint about the care provided to Mr M, who suffered from Parkinson's Disease, during his admission to hospital between 5 January and 13 March. She said that the Health Board failed to provide adequate and appropriate physiotherapy to Mr M, to communicate appropriately with Ms F about the care Mr M was receiving, and to prescribe, monitor and review Mr M's medication appropriately.

The Health Board acknowledged to the Ombudsman that it had overlooked the Case Study, owing to confusion around it being raised at the same time as the formal complaint and the Health Board's internal staff restructuring. It confirmed that it would commit time for the Parkinson's Team to consider the Case Study and identify any lessons that should be learned from it.

The Ombudsman found that the Health Board provided adequate and appropriate physiotherapy to Mr M, although more effort should have been made to ensure that Ms F was kept updated and involved, as she wanted to be, in Mr M's care. He also found that the Health Board did not review and manage Mr M's medication appropriately and that Mr M was inappropriately prescribed, and given, a single dose of haloperidol, which should never be given to patients with Parkinson's Disease and was likely to have caused Mr M to have suddenly declined three days later as well as increasing stiffness in his limbs. This potentially impacted on Mr M's ability to fully participate in, and benefit from, the physiotherapy provided.

The Ombudsman recommended that, within one month of the date of his report, the Health Board should apologise directly to Ms F for the inadequate communication and for the prescription of the haloperidol, as well as providing an apology for overlooking the case study and confirmation of what lessons had been taken from it. The Ombudsman also recommended that, within three months of the date of his report, the Health Board should:

- a) Consider how the Physiotherapy Team can ensure that the families of patients are better informed of the care being provided, and how to contact the team directly to request updates
- b) Conduct a review of its current provision of care for patients with Parkinson's disease and consider how it can ensure their care is overseen by a specialist, as per the NICE guidance
- c) Provide teaching to junior doctors across the Health Board (via an established platform) on the prescribing of medication to patients with Parkinson's Disease, in order to reduce the risk of this type of event happening in future.

[Beynon's Dental Practice - Clinical treatment outside hospital](#)

[Case Number: 201802416 – Report issued in May 2019](#)

Ms X complained about dental treatment that led to an extraction and treatment to an adjoining tooth in 2017. Ms X also complained about dental treatment in 2018 and about the Practice's complaint handling. In relation to a consultation in June 2017, the Ombudsman found that Ms X's clinical record lacked detail about alternative treatment options and lacked evidence that it was explained to Ms X why extraction of her tooth was the preferred option. In relation to a consultation in March 2018, he found that although Ms X's injustice was limited on this occasion as her tooth was not extracted, the clinical records were perfunctory and lacked detail. He also found that the Dentist's response to the complaint was emotive, did not properly address Ms X's complaint and the paucity of the clinical records meant that not everything in the response could be confirmed. The Ombudsman upheld the complaints. The Practice agreed to apologise to Ms X for the identified failings, make a redress payment of £250, reflect on the perfunctory nature of the clinical records and review whether further training is required and confirm that a postgraduate complaint handling course was added to the Dentist's Personal Development Plan.

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

[Case Number: 201801194 – Report issued in May 2019](#)

Ms X complained about her treatment between 18 and 26 June 2017, in particular whether appendicitis should have been diagnosed earlier than 27 June and whether her discharge from hospital on 12 July was appropriate.

The Ombudsman upheld the complaint and found that Ms X's treatment on 22 June only, was not appropriate and she should have been then diagnosed with appendicitis. The Ombudsman had no criticism of Ms X's discharge on 12 July. The Health Board agreed to implement the Ombudsman's recommendations and apologise to Ms X, make a redress payment of £3,000, ensure every surgical patient referred by A&E is reviewed by appropriate clinicians and to ensure this case is discussed at the Departmental Morbidity and Mortality meeting.

[Guilsfield Community Council - Various Other](#)

[Case Number: 201800944 – Report issued in May 2019](#)

Mrs X complained that Guilsfield Community Council (“the Council”) failed to follow relevant procedure, failed to be open and transparent, and failed to record accurate minutes when dealing with her correspondence during its meeting on 18 April 2018 (“the April meeting”). In particular, Mrs X complained that the Council chose to deal with it in private, but subsequently named her in the official minutes. Mrs X was also unhappy at the quality of the Council’s complaint response.

The Ombudsman’s investigation found that the agenda for the April meeting did not say that Mrs X’s correspondence would be discussed as a confidential item, and that during the meeting the decision to exclude the public was not done by resolution. The Ombudsman also found that it was inappropriate of the Council to deal with Mrs X’s correspondence in confidence yet name her in the approved minutes. The Ombudsman upheld this aspect of the complaint and recommended that the Council apologise to Mrs X and ensure her personal information was redacted from the approved minutes of the April meeting and any other meetings where appropriate.

With regard to the quality of the Council’s complaint response, it was noted that the Council failed to inform Mrs X how she could escalate her complaint further. The Ombudsman recently upheld a complaint about the Council’s complaint procedure, and it was considered that the recommendations agreed upon for that complaint were sufficient to address the shortcomings identified in this complaint.

Gowerton Medical Centre - Clinical treatment outside hospital Case Number: 201707920 – Report issued in May 2019

Mr G complained that GPs at a Practice in the area of Swansea Bay University Health Board:

- a) Failed to appropriately assess and manage the severe pain in his left hip and failed to adequately advise him about the potential side-effects of the analgesia he had been prescribed
- b) Failed to make appropriate efforts to expedite his referral for total hip replacement surgery
- c) Failed to respond to and/or adequately record his reports of deteriorating psychological health and suicidal ideation.

The Ombudsman upheld complaints 1 and 3. He found that GPs had incorrectly prescribed a type of analgesia whose primary use is in the management of neuropathic pain and that Mr G was not adequately advised about its potential side-effects. He also found that, contrary to clinical guidance, GPs failed to record and respond to Mr G’s reports of deteriorating psychological health and suicidal ideation.

The Ombudsman recommended that the Practice provides Mr G with a written apology and makes a payment to him of £500. He also recommended that GPs demonstrate that they have reviewed and reflected on the use of appropriate analgesia for non-neuropathic pain and on the importance of assessing and recording suicide risk in patients with chronic pain conditions.

The Practice agreed to implement these recommendations.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital Case Number: 201801867 – Report issued in May 2019

Mr X complained about the care and treatment his late brother-in-law, Mr Y, received from the Health Board. Specifically, Mr X complained that there was a delay in diagnosing and treating Mr Y’s cancer, that there was a failure to provide Mr Y with appropriate pain relief and palliative care and that there was a failure to adequately address Mr X and Mr Y’s concerns.

The investigation identified a delay between Mr Y’s scan and his case being considered by the multi-disciplinary team. Additionally, having referred Mr Y’s care to an English Hospital, there was a delay in providing the English Hospital with all of the information. The investigation also found that, since the Health Board did not have a keyworker available to support Mr Y, consideration should have been given to alternative support options such as palliative care at an earlier stage. Finally, the investigation found that the Health Board’s response to the complaints had addressed the issues that had been raised. The complaint

was partly upheld.

The Ombudsman recommended that the Health Board apologise to Mr Y's family for the service failure identified in this report. He also recommended that the Health Board undertake to continue its attempts to recruit a Sarcoma Clinical Nurse Specialist, and that the relevant clinicians consider the report during their next supervision sessions and identify and share any lessons that may be learned.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201802378 – Report issued in May 2019

Ms A complained about the care and treatment provided to her late mother, Mrs A, by Betsi Cadwaladr Health Board ("the Health Board") during three periods of admission to hospital. Firstly, Ms A said that those caring for her mother failed to have due regard to her pain and the management of it. Additionally, Ms A complained that a failure to undertake a scan resulted in a delay in the diagnosis of bowel cancer.

The Ombudsman upheld both of Ms A's complaints. The investigation found that Mrs A's pain, when recorded, had been done so at a very basic level and that an intensity scoring system had not been used. Further, the Ombudsman concluded that a scan should have been undertaken during the first period of admission. Whilst appreciating that there was no certainty that this would have identified Mrs A's bowel cancer, it is possible on balance that it would have done so, leading to at the very least an earlier diagnosis for her.

The Ombudsman recommended that the Health Board provide Mrs A with an apology for the failings in care identified and make a payment to her of £1000 in recognition of the uncertainty associated with the delay in diagnosis. The Health Board also agreed to review its use of an intensity scoring system on medical wards, reflect on failings identified with the medical team and discuss the findings with the clinicians concerned during their periodic supervision sessions.

[Canolfan Iechyd Amlwch - Clinical treatment outside hospital](#) Case Number: 201802376 – Report issued in May 2019

Ms A complained about the care and treatment provided to her late mother, Mrs A, by a GP Practice in the area of Betsi Cadwaladr Health Board ("the Practice"). Specifically, she complained that the GP's at the Practice failed to:

- a) Have due regard to nature and extent of pain experienced by Mrs A;
- b) Request or action in depth tests to rule out any other causes for the pain or symptoms;
- c) Identify and act upon symptoms which were strongly indicative of bowel cancer.

The Ombudsman upheld complaint 2 only. He was satisfied that the Practice appropriately diagnosed and treated Mrs A's recurrent urinary tract infections. However, the Ombudsman concluded that the Practice did not adequately consider other possible underlying causes for the recurrent infections or explore the possibility of further investigation of the underlying causes with her.

However, the Ombudsman determined that a GP working within the range of appropriate clinical practice would not have been expected to consider whether Mrs A had an underlying bowel cancer as a possible cause of the symptoms experienced.

The Ombudsman recommended that the Practice provides an apology to Ms A in relation to failing in care identified, reviews the complaint with the GPs involved in Mrs A's care and shares any learning with other clinicians at the Practice.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) Case Number: 201801304 – Report issued in May 2019

Miss A complained about the care and treatment received from the former Abertawe Bro Morgannwg

University Health Board (“the Health Board”). Miss A complained that the Health Board’s Obstetric and Gynaecology service failed to follow recommended procedures associated with her rare type of pregnancy when undertaking a biopsy. Additionally, Miss A complained that the Health Board did not adequately respond to her complaint, and that there was a failure to make reasonable enquiries with a specialist centre, to whom her care was later transferred, as part of its investigation.

The Ombudsman found that the relevant clinical guidance was not considered. He recognised however that the guidance did not explicitly advise against biopsy, and that, generally, only clinicians who had received specialist training would be aware of this. Nevertheless, the Ombudsman considered that, given the rare nature of the pregnancy, it would have been good clinical practice, for those treating Miss A, to have at least reviewed relevant guidance. Such action may have prompted an enquiry with a regional specialist centre for advice, and enabled an informed clinical decision to be made. The Health Board accepted, on reflection, that such action should have been taken.

Additionally, the Ombudsman upheld Miss A’s concerns about the way in which her complaint was investigated and responded to.

The Health Board accepted the Ombudsman’s findings and agreed to provide Miss A with an apology for the failings identified and make a payment to her of £1,250 in recognition of impact of them on Miss A. The Health Board also agreed to reflect on the findings with those involved in Miss A’s care during their periodic supervision sessions.

[Castle Gate Medical Practice - Clinical treatment outside hospital](#) [Case Number: 201803554 – Report issued in May 2019](#)

Ms A complained that the Practice failed to appropriately manage her urological condition and did not refer her to a relevant consultant in a timely manner. Ms A was also dissatisfied with the Practice’s handling of her complaint.

The investigation found that the Practice provided reasonable care to Ms A and there had been no clinical need to refer her to a consultant at an earlier stage. The substantive complaint was therefore **not upheld**.

The investigation found that the Practice’s initial complaint response was brief and failed to adequately address Ms A’s concerns, and that the Practice’s suggestion, during a complaint meeting, that Ms A should register elsewhere, was inappropriate. Ms A’s complaint about the Practice’s complaint handling was **upheld**. The Practice agreed to apologise to Ms A for the way in which her complaint was handled and for relevant staff to undertake complaint handling training.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) [Case Number: 201900804 - Report issued in June 2019](#)

Mr X complained that staff at Murryston Hospital in March/April 2017 had failed to ensure that he was provided with continuous IV fluids which had been necessary to prepare him for colorectal surgery. He complained that a urinary catheter was not managed appropriately causing him pain. He was aggrieved that toileting care was poor. He was concerned that, despite clear evidence of an eating disorder, he was inappropriately discharged and had to seek the help of his GP. Mr X complained that, despite being told that the malignancy of the polyp would only be confirmed after surgery and some weeks later, he was told before then by one doctor that it was malignant and by another when he should come back for chemotherapy. Mr X was aggrieved that when he raised issues with staff about the care being provided to him, these were either ignored or treated as complaints. Mr X was aggrieved that the Health Board, despite finding that there had been breaches of the duty of care, had failed to consider whether harm had been caused.

The investigation found no evidence that the breaks in provision of IV fluids had caused any significant

delay to Mr X's surgery. There was insufficient evidence that Mr X was suffering from an eating disorder or that his discharge had been unsafe. There was also insufficient evidence to support Mr X's complaint about how staff responded to the issues he raised about his care. These complaints were **not upheld**. A finding could not be reached on the complaint about toileting care given the irreconcilable and conflicting accounts.

The Health Board accepted that the management of the urinary catheter had been poor and had detrimentally affected Mr X. The investigation found, on balance, that the communication regarding the malignancy had been poor. The Health Board, despite finding shortcomings in Mr X's care when it conducted its own investigation, failed to consider whether these amounted to a breach of duty and whether Mr X was caused harm as a result. These complaints were **upheld**.

The Health Board had taken reasonable remedial systemic action in respect of the failings it accepted. To remedy the injustice to Mr X, the Health Board agreed to apologise for the failings found and to engage with him so as to determine suitable financial redress.

[Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital](#) Case Number: 201804363 - Report issued in June 2019

Ms B complained that the Health Board failed to provide appropriate treatment when she injured her wrists in 2017. Ms B also complained that the Health Board sent a scan (performed in January 2018) to the wrong consultant.

Ms B was treated conservatively by the Health Board. Ms B subsequently sought private treatment and surgery was recommended. The Ombudsman found that conservative treatment was appropriate at the time, and it was not possible to know whether the Health Board would also have recommended surgery if Ms B's condition did not improve. The Health Board acknowledged that there was confusion over the scan and said that the signature was not clear. The Ombudsman found that, irrespective of the signature, there was information on the record which clearly indicated where the scan should be returned to.

The Health Board agreed to apologise to Ms B for sending the scan to the wrong clinician and to undertake a review of the practice of clinicians in the Trauma and Orthopaedics department for following up scans, to ensure it is robust.

[Betsi Cadwaladr University Health Board - Clinical treatment in hospital](#) Case Number: 201801884 - Report issued in June 2019

Mr B complained about the care and treatment his wife received from the Health Board. He said there was an unreasonable delay in diagnosing and treating Mrs B with Hodgkin Lymphoma (an uncommon cancer that develops in the lymphatic system). He also complained about a decision relating to discharge, the implementation of a critical care plan and the procedure and communication around a decision not to attempt resuscitation.

The Ombudsman upheld the complaint about the delay in diagnosis. This was linked to a failure to accurately read a radiology scan which meant that the doctors treating Mrs B were not aware of the full clinical picture and did not conclude that Mrs B had Hodgkin Lymphoma for a number of months. The Ombudsman found that earlier treatment may have resulted in earlier chemotherapy, which could have slowed the disease rather than eradicated it, but which would have given Mrs B a few additional months of life. The Ombudsman did not uphold the other elements of the complaint.

The Health Board accepted the findings and has agreed to implement recommendations to apologise to Mr B and make a payment of £1000. The Health Board has also agreed that the Radiologist concerned should review the case with their supervisor.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201801617 - Report issued in June 2019

Miss A, who has scoliosis (which causes curvature of the spine), complained about her management and care during her labour and delivery at Ysbyty Glan Clwyd. She was also dissatisfied with aspects of communication including around a spinal block/epidural and the availability of an elective caesarean section. Finally, Miss A was dissatisfied with the Health Board's handling of her complaint, including inaccuracies in the Health Board's complaint response.

The Ombudsman's investigation concluded that broadly the care that Miss A received was appropriate and reasonable. However, as recognised by the Health Board, he concluded that communication and Miss A's epidural management could have been better. To that extent he upheld those aspects of Miss A's complaint.

The Ombudsman was critical of aspects of the Health Board's handling of Miss A's complaint including the accuracy of its complaint response and the failure to engage with a key clinician as part of the complaint process, despite criticism of the clinician in the complaint response. The Ombudsman upheld these parts of Miss A's complaint.

The Ombudsman's recommendations included the Health Board apologising and making a redress payment of £750 for the clinical and administrative failings which extended to complaints handling. He also made recommendations for the Health Board to consider aimed at ameliorating some of the impact caused by known maternal complications.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201802150 - Report issued in June 2019

Mrs A complained there was a failure to provide appropriate pressure care management to her son ("Child B"). She also raised concerns about complaint handling and the failure to adequately respond to the complaint in a timely manner.

The Ombudsman identified some shortcomings in Child B's care, namely:

- Lack of individualised care plan, contrary to relevant guidance.
- Inconsistent evidence of regular re-positioning, contrary to relevant guidance.
- Consideration was not given to an earlier referral for advice on Child B's skin management despite his skin showing signs of adverse pressure from admission.

Whilst the Ombudsman was unable to say the above action would have prevented Child B from developing a moisture lesion, it was possible that such preventative measures may have reduced the risk. This was an injustice. He upheld this complaint.

In terms of complaint handling, the Ombudsman did not find that any delay in responding was a result of any shortcoming on the Health Board's part. He did find that the response did not adequately reflect the shortcomings identified by his investigation. This was an injustice. He upheld this complaint.

The Ombudsman made a number of recommendations, including an apology, a financial redress payment for complaint handling, reminder to staff about relevant guidance on skin management and reviewing re-positioning documentation.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201801702 - Report issued in June 2019

Mr B complained about the care and treatment provided to his late wife Mrs B, concerning urology (urinary-tract system), emergency medicine and nursing care, and the way it handled his complaint.

The Ombudsman found the overall care and treatment provided by the Health Board to Mrs B following the nephrostomy procedure and a subsequent admission to Hospital, was of an acceptable standard and in accordance with guidelines, therefore these elements of the complaint were not upheld. However, the Ombudsman found that there were failures in communication, complaint handling and the time taken to assess Mrs B in the Emergency Department; he upheld these complaints.

The Health Boards agreed to apologise to Mr B for the failings identified, and to provide a redress payment of £500 for the distress and inconvenience caused, and to share the report with all relevant medical for critical reflection.

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

[Case Number: 201802266 - Report issued in June 2019](#)

Mr A complained that his late father, Mr B, was wrongly discharged from a hospital run by Aneurin Bevan University Health Board and that there was a failure to identify that he had a chest infection. Mr A also complained about elements of the nursing care provided to his father, including that staff did not take proper account of his father's deafness and called his father by his first name, which he never used.

The Ombudsman found that there was no clinical evidence that Mr B had a chest infection. He did not uphold that part of the complaint. In relation to the decision to discharge Mr B, there was a conflict between the evidence of the family and the Health Board as to Mr B's condition when he was discharged. Mr B sadly died two days later. On balance, the Ombudsman concluded that the decision to discharge Mr B was reasonable in the circumstances. The primary cause of death found post mortem (severe coronary artery disease) was unrelated to the reason Mr B had been receiving treatment in hospital, and could not have reasonably been predicted. In relation to the nursing care, the Ombudsman upheld the complaint. The Health Board had already accepted failings in the two areas Mr A had complained about.

The Ombudsman recommended that the Health Board apologise to the family for the failings relating to nursing care. He did not make any further recommendations on that point as the Health Board had already taken appropriate actions to improve its recording of patients' preferred names and communication with patients with hearing difficulties.

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

[Case Number: 201800718 - Report issued in June 2019](#)

Mrs X complained about the care her late husband received from Hywel Dda University Health Board. In particular, Mrs X was concerned:

- a) about the treatment Mr X received at Glan Gwili General Hospital during October and November 2016;
- b) whether Mr X's discharge was appropriate, and
- c) whether when Mr X was re-admitted to the Hospital the next day, his medical assessment and subsequent monitoring were correct.

The Ombudsman found that the care provided during Mr X's first admission was generally of an acceptable standard. However, there was one instance of a diuretic being given too soon after the previous dose. This did not cause Mr X any harm in practice. The Ombudsman acknowledged that the renal problem Mr X had been admitted with, and his pre-existing heart failure, meant that treating one without exacerbating the other was a difficult balance to achieve. Whilst the Ombudsman generally found the actions taken were reasonable, more consideration should have been given to restarting Mr X's heart failure medication before discharge, including discussing this with the cardiology team. In addition, there was a failure to weigh Mr X as often as he should have been, as this would have given greater certainty about whether his heart failure was progressing. To that extent, the Ombudsman upheld this part of the complaint. The Ombudsman did not uphold the complaint about the decision to discharge Mr X, as his observations suggested that his heart failure was stable at that time. When Mr X was readmitted, due to capacity issues he was taken directly to the ward

rather than to the Clinical Decisions Unit as planned. This meant the opportunity for a senior medical review on admission was missed. The lack of records between Mr X's admission and his sudden deterioration also meant that it was unclear whether any action could have been taken to prevent this. To that extent the Ombudsman upheld this part of the complaint. The Ombudsman found that the treatment Mr X received after being found unresponsive was of a good standard.

The Ombudsman recommended that the Health Board apologise to Mrs X and pay her £1,250 to reflect the injustice suffered by her husband as a result of the failings identified. He also recommended that the Health Board remind relevant staff of the importance of the frequent weighing of patients with known cardiac failure. The Health Board had already taken appropriate actions to deal with the other failings identified in the report.

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

[Case Number: 201806617 - Report issued in June 2019](#)

Mrs W complained that Aneurin Bevan University Health Board ("the Health Board") failed to ensure adequate post-operative care or give her appropriate information following an operation to remove a cyst, a benign swelling consisting of a collection of fluid or semisolid substance. Mrs W also complained that the Health Board failed to deal with her complaint appropriately or in a timely manner.

The Ombudsman found that Mrs W's plan of care and her discharge from hospital following surgery was appropriate; whilst she experienced unpleasant and distressing complications, they were not the result of any service failure on the part of the Health Board and could not have been predicted or prevented. However, Mrs W was not given appropriate advice or information about her clinical condition, how to care for her wound or what to do in the event that complications arose post-surgery. He also found that there was a failure to keep Mrs W appropriately informed when delays arose during the complaint process.

The Health Board had already developed a patient information leaflet to give to people in similar circumstances, which the Ombudsman thought was reasonable to ensure that patients are kept better informed in future. He recommended that the Health Board apologise to Mrs W and offer her £500 in recognition of the failures to ensure that Mrs W was fully informed and given appropriate advice after her surgery. He also recommended that relevant staff should be reminded of the importance of maintaining appropriate and meaningful communication when handling complaints.

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

[Case Number: 201801923 - Report issued in June 2019](#)

Ms A raised concerns about the care and treatment provided to her late mother, Mrs K, prior to her sad death in 2017. Ms A complained that Mrs K's care should have been escalated when her NEWS was recorded as high on two separate occasions on 4 September 2017. Ms A also said if Mrs K's care had been escalated the outcome might have been different. In addition, Ms A said that treatment should have been given to Mrs K when her care was escalated following a third high NEWS recording.

The Ombudsman's investigation found that there were missed opportunities to escalate Mrs K's care when her NEWS were recorded as high. On two occasions action was not taken, including assessment by a doctor, and this inaction meant Mrs K's family were not informed of her deterioration and were not present when she died. The Ombudsman could not be certain that had Mrs K's care been escalated the outcome would have been different. However, he was certain that further action by nursing staff should have led to a review by a doctor, who might have escalated her care to include the administration of intravenous fluids. This might have extended her life to enable Ms A and her family to be present at Mrs K's bedside. The Ombudsman, however, found that when Mrs K's NEWS was high for a third time, there was insufficient time for anything further to be done.

The Ombudsman concluded that there had been serious service failings by the Health Board and the injustice to Ms A was significant. He recommended an apology, and financial redress totalling £2,000 for Ms A. The Ombudsman also asked the Health Board to provide evidence of the improvements it said it had made since Mrs

K's death.

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

[Case Number: 201801389 - Report issued in June 2019](#)

Mrs T complained about the treatment, surgery and care she received from Aneurin Bevan University Health Board ("the Health Board") from 25 July 2016 onwards. In particular, Mrs T was unhappy with: the unsuccessful surgery on her left foot, subsequent actions which did not improve the positioning of her foot, and the standard of care following her surgery. Mrs T was also unhappy with the Health Board's complaint response. Mrs T said it was full of medical jargon, meaning she did not understand it completely and so could not be reassured that the Health Board managed her care appropriately. The Ombudsman's investigation found that Mrs T's overall treatment, surgery and care was appropriate and to an acceptable standard. Mrs T gave informed consent prior to surgery, and the risks were explained to her. Mrs T's follow-up care was appropriate and, correctly, a second opinion was sought recommending conservative management rather than a second operation. This part of the complaint was not upheld.

The Ombudsman, however, did agree with Mrs T that because her complaint response letter was full of technical jargon, it was difficult to understand and be certain the Health Board's actions were appropriate. The Ombudsman also found that the complaint response letter included details of unrelated medical issues that Mrs T was experiencing and receiving treatment for, thus confirming the letter had not been reviewed carefully enough before being sent to Mrs T. The Ombudsman upheld this aspect of the complaint and recommended that the Health Board apologise to Mrs T.

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

[Case Number: 201802296 - Report issued in June 2019](#)

Mr G complained about the care and treatment he received during and after a scheduled vasectomy operation that he underwent at Llandrindod Wells Hospital in March 2017. Mr G complained that:

- a) Due to the excessive pain and discomfort caused by the 'poor skills' of the Surgeon, the procedure, carried out under local anaesthetic, was abandoned before completion
- b) In the days following, the pain and swelling became so severe that he underwent emergency surgery at a hospital in England to remove a large haematoma (a solid swelling of clotted blood) and an abscess (a pus-filled infection) from his scrotum
- c) Despite receiving an assurance that the procedure would be re-scheduled and carried out under general anaesthetic, he heard nothing further from the Health Board
- d) The Health Board's handling of his complaint about this matter was deficient and unreasonably protracted.

The Ombudsman did not uphold Mr G's complaints about the standard of surgery conducted or the adverse, post-operative complications that he suffered. The Ombudsman found no evidence of a failure in surgical technique and found that the Surgeon acted correctly in abandoning the procedure when he was unable to palpate (feel) the vas (the sperm-carrying tube). The Ombudsman also found no evidence that the haematoma and post-operative infection (which are risks associated with the procedure) were attributable to any failing on the Surgeon's part.

However, the Ombudsman upheld Mr G's complaints about the failure to re-schedule the procedure and about the Health Board's protracted and deficient handling of his complaint. The Ombudsman also found that there was a failure by the Surgeon to adequately record the pre-operative consenting process in accordance with guidance issued by the General Medical Council (GMC).

The Ombudsman recommended that the Health Board provides Mr G with a written apology for the communication and complaint-handling failings and makes a payment to him of £250 in recognition of the time and trouble to which he was put as a result.

The Ombudsman further recommended that the Health Board shares the report with the Surgeon and with the Health Board's Clinical Director and obtains an undertaking that the Surgeon will review and reflect upon GMC guidance governing the recording of the consenting process. The Ombudsman also recommended that the report is shared with the Concerns Team and that the identified investigation and complaint handling shortcomings are discussed and reflected upon.

The Health Board agreed to implement these recommendations.

Argyle Medical Group - Clinical treatment outside hospital

Case Number: 201801058 - Report issued in June 2019

Mr G complained that GPs at a Practice ("the Practice") in the area of Hywel Dda University Health Board failed to adequately assess an injury that his mother, Mrs F, sustained to her left knee. Mr G complained that, despite his mother's symptoms of pain, swelling and restricted movement (and despite her history of osteoporosis), GPs prescribed pain relief only and did not consider that her injury warranted an X-ray. When an X-ray was performed some five weeks later, it revealed that Mrs F had sustained a fracture of her left femur just above the knee.

The Ombudsman found that the assessment of Mrs F's injury was inadequate and failed to comply with NICE guidance. He found that GPs had not considered how Mrs F was at risk of a low-energy fracture due to her osteoporosis and that the absence of any report of a fall was not sufficient to reasonably exclude a serious cause of her knee pain. The identified failings significantly delayed Mrs F receiving an accurate diagnosis and this led to her suffering pain, discomfort and to a loss of mobility which, in view of her age and frailty, is unlikely to be restored.

The Ombudsman recommended that the Practice provides Mrs F with a fulsome written apology and makes a payment to her of £250 in recognition of the distress that the delayed diagnosis and treatment gave rise to. The Ombudsman also recommended that this report is shared with the Practice GPs and that they discuss NICE guidance on the assessment of knee pain at their next NHS appraisal.

The Practice agreed to implement these recommendations.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201707449 - Report issued in June 2019

Ms D complained about the care and treatment she received at the University Hospital of Wales ("the Hospital") following an operation that she underwent to remove her gallbladder in July 2017. Ms D described how, four days after her discharge, she developed acute abdominal pain which required her to be re-admitted. She was again discharged (after two days) but, on returning home, received a telephone call from the Hospital informing her that blood test results reviewed that day showed a concerning rise in her inflammatory markers. Ms D was urged to return to the Hospital immediately to be re-admitted. Ms D also complained (in respect of her second admission) that:

- a) she was discharged with severe and unresolved abdominal pain;
- b) a physiotherapist had insisted that she mobilise and walk to the toilet despite it being evident that she was in acute, debilitating pain;
- c) clinicians informed her that she had suffered a post-operative haematoma (a solid swelling of clotted blood) which was infected and would require draining, then subsequently changed the diagnosis to generalised, post-operative inflammation.

The Ombudsman upheld Ms D's substantive complaints that she was prematurely discharged (two days after returning to the Hospital) with severe and unresolved abdominal pain. The Ombudsman determined that Ms D's blood test result should have been checked prior to her discharge and that her pain control should have been optimised/reviewed before she was allowed to leave the Hospital.

The Ombudsman did not uphold Ms D's complaints that she had been inappropriately mobilised by a physiotherapist or that the suggested diagnosis of a haematoma was amended.

The Ombudsman recommended that the Health Board provide Ms D with a written apology for the clinical and communication failings the investigation identified and make a payment to her of £500 in recognition of the distress, avoidable pain and anxiety these failings gave rise to.

The Ombudsman further recommended that the Health Board:

- a) Shares the report with the Second Consultant and the surgical team based on the SSSU and demonstrates to the Ombudsman that all have been reminded of the requirement to ensure that outstanding blood or other test results are obtained and reviewed prior to a patient's discharge.
- b) Demonstrates that SSSU physicians have been reminded of the requirement to ensure that patients referred to the Pain Team and/or suffering significant levels of pain are appropriately assessed/followed up prior to their discharge to ensure that analgesia is optimised and that patients are provided with pain management information.
- c) Considers developing a discharge checklist that refers to the requirements set out in the above recommendations and reminds clinicians to carefully utilise such a checklist during the discharge process.

The Health Board agreed to implement these recommendations.

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

[Case Number: 201803998 - Report issued in June 2019](#)

Mr X complained about the care and treatment provided to his late wife, by the Health Board. Mr X complained that staff failed to investigate, diagnose and treat the cause of Mrs X's pain and abdominal swelling. He said that staff failed to complete a NEWS score on the evening of her death and review or seek any instruction as to Mrs X's resuscitation status.

The Ombudsman found that appropriate medication was provided and investigations undertaken in response to Mrs X's complaints of pain. However, the timeliness of some of these investigations was concerning and contributed to a delay in review by a Doctor. He considered that an earlier diagnosis may have enabled those caring for Mrs X to commence end of life care sooner, easing the distress caused to her and the family. Furthermore, although staff did not complete a NEWS score, the patient notes demonstrated awareness of Mrs X's deteriorating condition, and that appropriate action had been taken in response. On this basis, the complaints relating to care and treatment were partly upheld. Finally, the Ombudsman found that there was a failure to review Mrs X's resuscitation status and upheld this aspect of the complaint.

The Ombudsman recommended that the Health Board apologise to Mr X and make him a redress payment of £1000 to reflect his findings. He also recommended that the Health Board share his findings with relevant staff and audit its compliance with the national policy on obtaining, clarifying and demonstrating the resuscitation status of relevant patients. The Health Board agreed to implement the recommendations.

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

[Case Number: 201802391 - Report issued in June 2019](#)

Ms A complained about the treatment of her late mother by Welsh Ambulance Services NHS Trust ("WAST") in February 2018. Ms A complained that the delay between the initial call to WAST and the arrival of an ambulance was excessive. Additionally, Ms A complained that WAST's response to her complaint was a standard reply which referred to her mother as her father.

The Ombudsman's investigation noted that WAST was experiencing a high demand for its service at the time of Ms A's calls and had significant difficulties in transferring patients conveyed to hospital during this timeframe. WAST acknowledged that the response time fell below the service standard it aimed to provide.

Although calls made to the service were categorised appropriately by WAST, the investigation found that a welfare check was not undertaken during the period Ms A's mother was waiting. Whilst there was no certainty that a welfare check would have resulted in re-categorisation to a higher level, it is possible that it would have done so, and that a Rapid Response Vehicle might then have been dispatched sooner. The investigation identified also that a poor decision was made in relation to the dispatch of a vehicle earlier. The Ombudsman determined also that the handling of Ms A's complaint by WAST did not accord with Principles of Good Administration. Ms A's complaints were partly upheld.

On the basis of the Ombudsman's findings WAST agreed to apologise to Ms A for failings identified, make a redress payment to her in respect of them and time and trouble taken to pursue the complaint and consider creating a protocol for welfare calls.

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

[Case Number: 20170807 – Report issued in June](#)

Mr X complained that there had been an unreasonable delay on the part of the Health Board in arranging dental implants and denture treatment. Mr X was aggrieved that the ongoing failure to address the issue had caused detriment to his physical and mental wellbeing. Mr X said he suffered from stress and was unable to obtain adequate nourishment from his diet, which affected his health. He attributed recent health issues, including vitamin deficiencies and heart problems, to the absence of dental treatment and the stress of trying to seek a resolution. Mr X said that his poor diet and lack of teeth had affected his ability to socialise and interact with people.

The investigation found that the lack of urgency, on the part of the Health Board, in exploring options to seek to address Mr X's dental issue, and the other issues indirectly caused by his lack of teeth, amounted to service failure. The investigation found that Mr X had not had the care and treatment he needed for approximately a year. Also, the time expended by Mr X trying to get a resolution to his predicament also amounted to an injustice. The complaint was, therefore, **upheld**.

The Health Board agreed to apologise and make a payment of £750 to Mr X and to undertake a focused review of restorative dentistry care provision.

Not Upheld

[Skewen Medical Centre - Clinical treatment outside hospital](#)

[Case Number: 201802507 – Report issued in April 2019](#)

Miss X complained that when she described her symptoms to a GP Practice in the area of Abertawe Bro Morgannwg University Health Board over the telephone, they did not provide her with appropriate or reasonable care. Miss X was diagnosed with a muscle strain and prescribed pain relief medication during a telephone consultation with a GP at the Practice. She was admitted to hospital less than two days later with a severe pneumonia.

The investigation found that the telephone consultation was undertaken appropriately by the GP, and that the diagnosis given to Miss X was reasonable, based on the information that Miss X provided during the telephone call. The decision by the GP not to see Miss X face to face was within a range of safe clinical practice and was therefore reasonable. The complaint was **not upheld**.

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

[Case Number: 201704187 – Report issued in April 2019](#)

Mrs X complained about the poor standard of care provided to her late father-in-law, Mr Y, at the Royal

Gwent Hospital in June 2016, when he sadly died. Mrs X was of the view that the poor care happened because he was admitted over a weekend and lower staffing levels may have had a detrimental effect on the standard of care provided and his chances of survival. Mrs X was aggrieved that Mr Y's care was not properly escalated when he was unwell and when he deteriorated. She was of the view that this may also have affected Mr Y's likelihood of survival.

Mrs X complained about how the Health Board handled her complaint about the matter. She was aggrieved about the inaccuracy of the Health Board's complaint response letter and by the expectation raised that the case would be considered by a Redress Panel, which did not then happen.

The investigation found that there were a number of significant failings in the care provided to Mr Y, which amounted to service failure. However, we could not conclude that the service failure caused any detriment to Mr Y.

With respect to the complaint handling issue, the investigation found that the Health Board's complaint response did not contain any significant factual inaccuracies, although its conclusions about the standard of care provided were not consistent with this office's views. We did not consider that the failure to consider the case at a Redress Panel was likely to have caused any injustice as the determination of any potential liability was based on the same information.

The complaints were, therefore, **not upheld**.

[Cardiff and Vale University Health Board- Clinical treatment in hospital](#) [Case Number: 201800070 – Report issued in April 2019](#)

Ms X complained that there had been an unreasonable delay on the part of Cardiff and Vale University Health Board ("the Health Board") in diagnosing and treating her late mother's ("Mrs Y") liver cancer. Mrs Y had been under the care of the Health Board in respect of abdominal pain since May 2016 but the cancer was not suspected until September 2017 and confirmed shortly afterwards.

The investigation found that there had been no unreasonable delay in diagnosing Mrs Y's cancer and no delay in treating it. The delay in diagnosing the cancer did not reflect poor technique or misinterpretation of the radiological scans undertaken to investigate Mrs Y's abdominal issues but suggested the rapid growth of tumour tissues and its composition being very similar to normal liver. The complaint was **not upheld**.

[Betsi Cadwaladr University Health Board - Other](#) [Case Number: 201805010 – Report issued in April 2019](#)

Mr B complained that the Health Board Out of Hours service provided advice that did not match the urgency of his symptoms, and that the Nurse Practitioner did not take into account his wife's disability and pressurised her into cancelling the ambulance.

The Ombudsman found that there was nothing to suggest that the advice given was not appropriate. He found that the Nurse Practitioner was firm but courteous and the conversation was reasonable and appropriate. The Ombudsman did not uphold the complaint.

[Welsh Ambulance Services NHS Trust - Ambulance Services](#) [Case Number: 201805007 – Report issued in April 2019](#)

Mr B complained that WAST demonstrated intolerant, dismissive and prejudicial behaviour towards his wife Mrs B. Mr B said that WAST did not take into account Mrs B's vulnerability as Mr B is her full-time carer. The Ombudsman found that WAST gave reasonable advice based upon the information available to it. He also found that the Call Handler noted Mrs B's disability and gave advice. The Ombudsman **did not uphold** the complaint.

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

Case Number: 201800217 – Report issued in April 2019

Mr A complained on behalf of his wife, Mrs A, about the Health Board's management of surgical revisions to her left hip-replacement. Mr A said that the Health Board's failure to X-ray Mrs A hip before mobilising her following the first revision surgery had resulted in serious post-operative complications. Mr A also complained about the waiting time before a second revision surgery was to be carried out and about delays by the Health Board when responding to his complaint.

The Ombudsman found that both the decision to mobilise Mrs A and the timing of her X-ray after the first revision surgery were reasonable in the absence of surgical concerns. He concluded that the complications experienced by Mrs A were as a result of recurrent infection that persisted, despite monitoring and appropriate treatment, as opposed to there being any evidence of failures in her management.

Although there was some evidence of miscommunication with Mr and Mrs A regarding the expected waiting time for the second revision surgery, the Ombudsman did not find any clinical need for Mrs A's surgery to have taken place at an earlier time. The investigation also found an unreasonable delay by the Health Board when issuing its prepared complaint response which meant that the content was no longer accurate as it had been superseded by events.

The Health Board agreed to apologise to Mr A and to pay him £125 in recognition of the failings identified. It also agreed to review its case management to ensure closer monitoring and progression of prepared complaint responses.

Aneurin Bevan University Health Board - Clinical treatment in hospital

Case Number: 201800573 – Report issued in April 2019

Ms A complained about the care and treatment of her late father (Mr B) at a Health Board hospital ("the Hospital"). Mr B suffered a fatal gastric bleed, having undergone elective surgery for a hernia repair some days previously. Ms A's concerns centred around whether Mr B had been properly made aware of the risks of undergoing surgery by the surgeon ("the Surgeon") performing it, and his postsurgical medical management (including his anticoagulation medication). She considered that failures in managing his medication had caused the fatal bleed.

Whilst there were shortcomings in the consenting process (the Surgeon failed to properly record his discussion with Mr B), there was sufficient evidence that Mr B had been fully informed of all known and foreseeable risks (including a properly documented discussion by another clinician telling him that he might die). Advice obtained from one of the Ombudsman's professional advisers confirmed that there were some failings in completing monitoring charts, and in dealing with Mr B's anti-coagulation medications on one day. However, these occurred days before Mr B died and so did not affect the outcome. Mr B's gastric bleed was an unforeseeable complication, not linked to his hernia. In line with his jurisdiction, the Ombudsman could **not uphold** the complaint. Nevertheless, he made some suggestions for improvement and learning which the Health Board voluntarily agreed to implement. These included:

- a) Sharing the report's findings with surgical staff at all its hospitals to ensure there was critical reflection about properly documenting consent discussions.
- b) Undertaking an audit of anticoagulation monitoring and other charts on the ward where Mr B was a patient.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Number: 201801351 – Report issued in May 2019

Ms A complained about an operation to treat a long term skin condition which was carried out at a Private Hospital but paid for by the NHS. Unfortunately, Ms A's stitches burst shortly after the operation took place, prolonging her recovery. Ms A was particularly concerned about the discharge and post-operative aftercare arrangements.

The Ombudsman concluded that the standard of care was broadly reasonable, but was concerned about some aspects of the discharge arrangements from the Private Hospital, particularly in relation to the information Ms A was given at the time. The Ombudsman upheld the complaint against the Private Hospital to that extent only. He did not uphold the complaints against the Health Board. The Ombudsman recommended that the Private Hospital apologise to Ms A and review its discharge arrangements, particularly the information given to patients.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201805495 – Report issued in May 2019

Mrs F complained about the care and treatment provided by the Health Board to her late husband, Mr F, in the Emergency Department of University Hospital of Wales Hospital on 16 November 2017. Mr F was admitted with chest pain and tightness. The junior doctor who assessed Mr F, ordered investigations to rule out a spectrum of conditions associated with sudden, reduced blood flow to the heart. The tests proved normal and Mr F was discharged home the same day. Sadly, Mr F died at home later that day, from an aortic dissection (a serious condition in which there is a tear in the wall of the major artery carrying blood out of the heart).

The Ombudsman found that reasonable care and treatment had been given to Mr F by the Health Board and that the sad outcome could not have been predicted. The Ombudsman therefore, did not uphold this complaint. The Health Board confirmed that the junior doctor was no longer in its employment, but it had contacted them and advised that they would meet with their supervisor to discuss this case and reflect thoroughly on the events. The Health Board recognised that Mr F had to wait over four hours to be seen by a doctor in the Emergency Department, and although the Ombudsman found that this delay did not have an impact on Mr F's care, treatment or discharge from hospital, the Health Board had already apologised to Mrs F for this delay.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201802784 – Report issued in May 2019

Mr A complained about the care and treatment he received from the Health Board in relation to a Brachiocephalic Arteriovenous Fistula Formation procedure (the connection of a vein and an artery, causing more blood to flow through the vein) ("the procedure") on his left arm, to aid kidney dialysis. Mr A also raised his concerns about the consent process for the procedure and the reasonableness of the Health Board's complaint response.

The complaint was not upheld. The Ombudsman concluded that the Health Board had acted reasonably in carrying out the procedure and obtaining correct consent. Whilst the Health Board's complaints response did not include information about some relevant tests, overall it was reasonable and the omission did not have a significant impact. Whilst not upholding this element of the complaint the Ombudsman asked the Health Board to ensure it carefully considered the relevance of including all aspects of a person's medical history in future complaints response correspondence.

Newtown Medical Practice - Clinical treatment outside hospital

Case Number: 201803751 – Report issued in May 2019

Mrs A complained that General Practitioners ("GPs") from the Practice did not carry out home visits when requested. She also complained that one GP from the Practice was rude to her when she telephoned to request a home visit. Mrs A said that the Practice showed a lack of duty of care to her as a patient and that, as she only lived forty minutes away from the Practice, GPs should have been able to travel to her home address.

The Ombudsman did not identify any evidence to suggest that home visits should have been conducted, or that the GP who spoke to Mrs A was rude to her. The Ombudsman did not consider there was any service failure in the treatment provided by the GPs at the Practice, and did not uphold these complaints.

Cardiff and Vale University Health Board - Clinical treatment in hospital

Case Number: 201804798 – Report issued in May 2019

Mrs R complained that, while her sister (“Mrs C”) was admitted to hospital between Friday 8 and Wednesday 13 December **2017**, Cardiff and Vale University Health Board (“the Health Board”) failed to assess and monitor Mrs C’s condition properly, or take prompt action to provide her with appropriate treatment. She also complained that the Health Board did not communicate effectively with Mrs C and her family about her condition, and her prognosis.

The Ombudsman found that there was no evidence of any failure on the part of the Health Board to identify that Mrs C was suffering from an aggressive form of cancer. However, it was not appropriate to begin treatment without confirmation of the type of cancer and, given Mrs C’s apparent relative stability in the first few days of her admission, it was sensible to wait until the laboratory was able to process the relevant test results after the weekend. When Mrs C began to decline and then suddenly deteriorated on 12 December, the Health Board responded promptly to the changing clinical picture and provided maximal care to try to save her life. Sadly, it was not possible to prevent the disease from overwhelming Mrs C and she died on 13 December.

In relation to the level of communication, Mrs R said that the family had nominated Mrs C’s husband to liaise between the Ombudsman and hospital staff. The records reflected that Mrs C and her husband were both kept fully informed of her clinical condition and care plan.

The Ombudsman did not uphold the complaints.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Number: 201800100 – Report issued in May 2019

Mr J complained that, following an operation to remove his gall bladder (a cholecystectomy) at the Royal Glamorgan Hospital in October 2016, he developed, post-discharge, a severe infection which led to him being re-admitted in January 2017. During this second admission, Mr J developed sepsis and was treated in the Intensive Care Unit. Mr J complained that, although clinicians eventually identified his infection as endocarditis (an infection of the inner lining of the heart chambers and valves), the Health Board did not accept that it was linked to his gall bladder surgery or to his post-operative care. Mr J also complained that, due to the amount and type of antibiotics that he received, he subsequently experienced significant hearing loss.

The Ombudsman, through his Clinical Adviser, could find no evidence of the source of the organism that caused Mr J’s endocarditis and no evidence of any operative or post-operative failing on the part of clinicians that could have led to him contracting this infection. The Ombudsman also determined that the amount and type of antibiotics that Mr J was given were reasonable in the circumstances (as a life-saving measure) and that clinicians monitored antibiotic levels to ensure that they did not reach toxic levels in the blood.

The Ombudsman agreed that there was a circumstantial association (or broad correlation) between Mr J’s surgery and his subsequent infection, but, in the absence of any evidence of a clinical failing or omission on the part of Health Board clinicians he could find no grounds to uphold the complaint.

The Rogerstone Practice - Clinical treatment outside hospital

Case Number: 201802434 – Report issued in May 2019

Mrs A complained about the care and treatment her husband, Mr A, received from the Practice for a lesion on his back. Specifically, Mrs A complained that Mr A should have been referred to hospital for the surgical removal of the lesion. Mrs A also said that Mr A should have been advised to stop taking warfarin prior to surgery and while taking antibiotics. Mrs A complained that there was a failure to appropriately close the wound and follow-up the surgery, leaving Mr A open to infection, and there was a failure to

appropriately refer Mr A for treatment following signs of jaundice. Finally, Mrs A said that the Practice failed to appropriately respond to the complaint.

The investigation found that the care and treatment Mr A had received had been appropriate and that the surgery was completed under supervision. The investigation also found that, in view of Mr A's stable condition it was not necessary for him to stop taking warfarin prior to surgery or while taking antibiotics. The investigation found that the wound had been appropriately closed, and that the wound, infection and subsequent jaundice were adequately managed. Finally the investigation found that the complaint response addressed the concerns that had been raised by Mrs A.

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

[Case Number: 201802357 – Report issued in May 2019](#)

Mrs A complained that there had been a delay in diagnosing and treating her husband, Mr A's, Hodgkins lymphoma (a form of cancer of the lymphatic system).

The investigation found that, although the clinicians believed that Mr A had Hodgkins lymphoma, unfortunately, the position of the cancer made it difficult to access a suitable specimen to biopsy and reach a formal diagnosis. The investigation also found that there was no delay in commencing treatment once a diagnosis had been made.

The complaint was not upheld.

[Cwm Taf University Health Board – Other](#)

[Case Number: 201900804 - Report issued in June 2019](#)

Mrs X complained about how road safety assessments of her mother, Mrs Y, who had a diagnosis of Early Alzheimer's Disease, were undertaken on 7 & 10 April 2017. Mrs X said that she was given inadequate notice of the assessments, being unaware that the assessments were to take place on those dates. She was of the view that the assessments were poorly planned, that inadequate safeguards were put in place, that Mrs Y was not properly supervised and that she was made to walk too far (given that she had been an in-patient for months). On 10 April, Mrs Y fell and injured her head.

The investigation found no evidence that Mrs X was made aware of specifically when her mother's assessment(s) would take place; it would have been preferable if this information had been offered to her. The Health Board's Occupational Therapy Service acknowledged this shortcoming in communication and said that, in future, it would endeavour to communicate directly with family members rather than through other agencies (e.g. Social Services etc.). The investigation found that the assessments had been carried out according to the usual parameters. The Mental Health Occupational Therapists used the risk assessment information available and could not have foreseen that Mrs Y would fall during the assessment. They also provided suitable support to Mrs Y after the fall. The investigation found that the assessments had been undertaken appropriately so the complaint was not upheld.

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

[Case Number: 201802562 - Report issued in June 2019](#)

Mr B complained about the care given to his son "C". He said that C, who had feeding difficulties, had not been properly diagnosed and would benefit from different support to that provided by Aneurin Bevan University Health Board ("the Health Board"). Mr B also said that the Health Board failed to follow its own procedures and provided conflicting advice in respect of travelling with C for an assessment. The Ombudsman did not uphold the complaint.

The Ombudsman found that although Mr B's expectations and preferred method of care was different from that delivered by the Health Board, the care given to C was appropriate and any delays in the process necessary to ensure that all avenues were appropriately explored. C's needs are complex and in addition to providing suitable and relevant care the Health Board attempted to facilitate the choices of C's

parents.

The Ombudsman found that the referral outside of the area, which would involve travel, was made to support Mr B's preferred treatment and the advice on travelling, given by the Health Board was reasonable, although it was acknowledged that travelling with C would be challenging.

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

[Case Number: 201802115 - Report issued in June 2019](#)

Mr E complained about the delay in the Welsh Ambulance Services NHS Trust responding to calls made for his mother, Mrs D.

The Ombudsman found that, although there had been minor errors in the way in which WAST handled the calls, the calls had been correctly categorised. All available resources were committed to, or on their way to, higher priority calls, and WAST had made every effort to attend Mrs D's home as soon as reasonably practicable within the available resources. Any concerns which the Ombudsman's professional adviser identified had no bearing on the service provided, and the complaint was therefore not upheld. However, the Ombudsman invited WAST to consider the concerns identified, and what actions it could take to ensure the errors were not repeated.

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

[Case Number: 201804327 - Report issued in June 2019](#)

Ms X complained about the care and treatment she received following sub-talar fusion surgery (an operation to join the bones of an affected joint together) in March 2017. She was concerned that her ankle was fused using metal screws despite telling the Consultant she was allergic to metal, the quality of stitching was poor which left a scar on her foot, and the screws caused an infection in her foot which meant she had to undergo further surgery to remove the screws and clean out the infection site.

The Ombudsman found that neither the clinical records nor pre-operative assessment documented an allergy to metal. The references to a metal allergy only appeared in Ms X's records after the date of the surgery. On this basis, it was acceptable for metal screws to have been used in the surgery and their use was in line with standard clinical practice. He also found that the quality of stitching was within the bounds of acceptable clinical practice. Finally, infection is a recognised complication of foot surgery and there was no indication that Ms X's infection was as a result of sub-standard care and treatment. The reason for their removal was clinically appropriate. The Ombudsman did not uphold Ms X's complaints.

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

[Case Number: 201801423 - Report issued in June 2019](#)

Ms C complained that the Health Board did not provide reasonable postnatal care and treatment to her and her newborn baby and failed to diagnose a Tongue-Tie, which was later identified and treated by a private healthcare professional.

The Ombudsman found the matter was subject to differing opinion between NHS and private healthcare professionals and, as no clinical photographic evidence was available to determine its existence, he was unable to conclude robustly that the condition was present. The Ombudsman also found the Health Board provided reasonable postnatal care and treatment in line with guidance, and took appropriate and timely action to address Ms C's concerns in offering support and a second opinion which was not taken up, and the complaint was not upheld.

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

[Case Number: 201801641 - Report issued in June 2019](#)

Mrs A complained about the care and treatment provided to her two year old son ("child B") by the Welsh Ambulance Services Trust ("WAST"). Mrs A said that the WAST paramedic administered 10mg of Diazepam to child B and later misinformed the doctors at the ED that a lower dose (2.5mg) had been administered.

The Ombudsman was concerned that miscommunication had led to child B being administered a lower dose of the medication than needed to help stop his seizure. That said, it was difficult to say whether the correct dosage of medication would have made a difference. Whilst this was a service failing, given that there were no long-term consequences for child B, the Ombudsman was unable to say that there was a significant injustice caused to child B and therefore did not uphold Mrs A's complaint.

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

[Case Number: 201802423 - Report issued in June 2019](#)

Mr L complained that Cardiff and Vale University Health Board ("the Health Board") delayed moving his mother, Mrs M, out of the Emergency Department ("ED") resulting in her falling and fracturing her hip. Mr L said that due to his mother's insomnia, the risk of her falling was high and that staff failed to mitigate this risk. The Ombudsman's investigation found that appropriate steps were taken by staff to mitigate the risk of Mrs M falling during her time in the ED. A falls assessment was carried out and it was determined that there was no requirement for enhanced supervision. The Ombudsman could not find any evidence that Mr L made staff aware that Mrs M's suffered from insomnia due to her dialysis until after her fall. Also whilst it was regrettable, the Ombudsman found that Mrs M's longer than planned stay in the ED did not contribute to her fall. The Ombudsman therefore did not uphold Mr L's complaint.

However, late in his investigation, the Ombudsman was made aware of a serious incident report that the Health Board was required to submit to Welsh Government following Mrs M's fall. The Health Board highlighted that some documentation had not been completed, Mrs M was not nursed in an observable area, and further information about what happened following the fall had to be obtained through statements from staff. Whilst the Ombudsman was satisfied that the report did not alter his final conclusions, and the improvements the Health Board said it had made since were reasonable, he was disappointed that it was originally not provided and that it did not inform the complaint response sent originally to Mr L. The Ombudsman suggested that in future the Health Board takes steps to ensure complainants such as Mr L were not deprived of all the facts.

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

[Case Number: 201802423 - Report issued in June 2019](#)

Mrs B complained to the Ombudsman about the care and treatment she received when she attended Ysbyty Ystrad Fawr Minor Injuries Unit ("the MIU") with an injury to her ankle that was later identified as a fragility (or 'stress') fracture. Mrs B complained that:

- Despite presenting with symptoms of pain, swelling and restricted movement (and despite explaining that her condition of Charcot Marie Tooth Disease made her prone to fractures), her injury was misdiagnosed as a sprain by an Emergency Nurse Practitioner.
- A radiographer who subsequently reviewed an X-ray of her ankle also failed to identify a fragility fracture.
- Her ankle 'gave way' some days later when she attempted to put weight on it. This led to her being taken to Prince Charles Hospital by ambulance where a fracture was identified, and where, following admission, she underwent surgery to repair it.

The Ombudsman **did not uphold** Mrs B's complaint. Through his clinical advisers, he found no evidence of a fragility fracture on the X-rays taken of Mrs B's ankle at the MIU. The Ombudsman therefore concluded that it was reasonable that Mrs B's injury was identified and treated as a sprain. The Ombudsman was pleased to note that, following Mrs B's complaint, the Health Board issued new guidance to all ENPs to refer patients with known osteoporosis (presenting with persistent pain on weight-bearing) to a fracture clinic for further investigation.

[Clinical treatment outside hospital - Chirk Surgery - Castle Health Centre](#)

[Case Number: 201802880 - Report issued in June 2019](#)

Ms X complained on behalf of her mother, Mrs Y, about the treatment that Mrs Y received during a home visit made by a General Practitioner ("GP") from the Health Centre in June 2018.

Unfortunately, Mrs Y fell and broke her hip while opening the door to the GP. Ms X complained that the GP did not examine Mrs Y appropriately after her fall, that she delayed in arranging for an ambulance for Mrs Y, and that she left Mrs Y alone and in an uncomfortable position, without informing Ms X that she would be returning to the Health Centre.

The Ombudsman did not uphold the complaint. He accepted that the GP had undertaken a reasonable assessment of Mrs Y after her fall. The Ombudsman found that it was not unreasonable that Mrs Y was left alone under the circumstances, or that the GP arranged for a non-urgent ambulance to take Mrs Y to hospital upon her return to the Health Centre.

Early Resolution or Voluntary Settlement

Beech House Surgery - Clinical treatment outside hospital

Case Number: 201807504 – Report issued in April 2019

Ms X complained to the Ombudsman on behalf of her brother. She had complained to the Practice about her brother's blood tests and a cancelled appointment and felt that, in responding to her complaint, the Practice Manager had spoken in an inappropriate manner to her over the phone .

The Ombudsman found that although the Practice had provided a formal written response to Ms X's concerns, the arrangements going forward for her brother's blood tests and the collection of the blood specimen bottles were not clear.

The Practice agreed to undertake the following actions, in settlement of the complaint:

- Clarify in writing to Ms X within two weeks:
 - a) What arrangements are in place to ensure blood tests can be completed at the Practice
 - b) Confirm that the Practice will collect the blood specimen (green top bottles) for the tests.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201807972 – Report issued in April 2019

The Ombudsman received a complaint from Mr B saying that Betsi Cadwaladr University Health Board ("the Health Board") had not responded to his concerns about the care and treatment received following minor surgery.

The Ombudsman found that the Health Board had not investigated Mr B's concerns under NHS Putting Things Right regulations. The Health Board therefore agreed

- a) To investigate Mr B's complaint under the NHS Putting Things Right regulations within 30 working days

Cardiff and Vale University Health Board - Clinical treatment outside hospital

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201806659 – Report issued in April 2019

Mrs X complained to the Ombudsman about a response she received from the Health Board to a complaint she raised, amongst other matters, about being designated a violent and aggressive patient. The Ombudsman found that the Health Board's response on this issue lacked sufficient detail and explanation. Therefore, the Health Board agreed to:

- provide Mrs X, within four weeks, a more explicit response on the issue of whether Mrs X is categorised by the Health Board as a violent or aggressive patient

Powys Teaching Health Board - Continuing care

Case Number: 201806805 – Report issued in April 2019

Mrs X complained to the Ombudsman about the length of time the Health Board had taken to determine her late mother's eligibility for NHS Continuing Healthcare ("CHC"). The Ombudsman found that the Health Board had exceeded the two year deadline set by the Welsh Government for making such decisions.

The Health Board therefore agreed to apologise formally to Mrs X for the delay in providing her with the outcome of its review into her mother's eligibility for CHC funding within four weeks.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201807674 – Report issued in April 2019

Mrs X complained that she received inappropriate advice and treatment from the Orthopaedic Department ("the Department") in Bronglais Hospital in relation to her hip. As a consequence she wanted the Health Board to refer her to Cardiff for a porcelain hip replacement operation.

The Ombudsman noted that Mrs X had sent a letter to the Health Board dated 4 January 2019. In that letter, she raised concern about being told she was too young to receive a total hip replacement. However, two other consultants whom she had seen independently indicated that she required an urgent hip replacement, and the treatment which she had received was inappropriate for her. Mrs X asked that the Health Board refer her out of area for a porcelain hip replacement operation. The Ombudsman also noted that the Health Board had not received Mrs X's letter until 7 February 2019, nonetheless it had not provided a written response.

The Health Board agreed to provide respond to Mrs X's letter in writing, within 21 days of the Ombudsman issuing his decision. The Health Board agreed that the response would include:

- a) Details about the Individual Patient Funding Request process.
- b) An explanation of why a second opinion is required and the impact of it not being obtained.
- c) Exploration of a second opinion being provided by a consultant within the Health Board, other than Mr Sonanis or Mr Omar.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Number: 201806817 – Report issued in April 2019

Mr X complained about his care at Wrexham Maelor Hospital stating that he was given somebody else's medication and had an allergic reaction to it, was tested for AIDS without consent, and that his bed pans were not changed for lengths of time. Mr X said that he has suffered with depression, organ failure, water retention and an enlarged testicle as a result of his care.

The Ombudsman considered that the complaint was open to early resolution given the delay Mr X experienced in pursuing his complaint, the content of the response from the Health Board and the new complaints raised. The Ombudsman was pleased to note that the Health Board agreed to settle the complaint on the following grounds:

- To apologise and pay Mr X £250 for the management and delay in handling his complaint.
- To provide Mr X with a response in accordance with Regulation 24 of Putting Things Right on his existing complaints and new complaints.
- Within a month of the Health Board's response, and if Mr X is agreeable, hold a meeting with him to discuss his complaint.

Local Health Board/NHS Trust - Clinical treatment in hospital

Case Number: 201807814 – Report issued in April 2019

Mrs D complained that there was a substantial delay in the diagnosis and treatment of her son's neurodevelopmental condition. Mrs D says that the Health Board failed to refer her son to the Integrated Services for Children with Additional Needs ("ISCAN"), and her son was incorrectly set up with two electronic patient records, which have now been merged.

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

By 25 April 2019:

Issue a further letter to Mrs D commenting specifically on whether:

- a) there has been a breach of duty of care;
- b) if there has, whether or not qualifying liability for harm suffered by Mrs D's son is appropriate or not with reasons.

Abertawe Bro Morgannwg University Health Board - Continuing care

Case Number: 201807904 – Report issued in April 2019

Ms S complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") did not award funding for her mother's nursing care. Ms S also complained that there was a delay in the Health Board's response, and the response did not fully address her concerns.

The Health Board has agreed to undertake the following in settlement of Ms S complaint:

By 22 May 2019:

Issue a further substantive response letter to Ms S commenting specifically on:

- a) Its complaint handling and the delay in its response;
- b) Its decision not to award CHC funding for Ms S's mother.

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

Cwmbran Dental Spa - De-Registration

Case Number: 201807300 – Report issued in April 2019

Mr X complained about being refused future NHS dental treatment by the Practice because an appointment was cancelled at short notice.

The Practice noted that there had been previous missed appointments, late attendances, and late appointment cancellations. Its policy was that two such 'failed' appointments would result in NHS treatment being withdrawn and it stated that this was in line with NHS guidance.

The Ombudsman contacted the Practice. In the specific circumstances of this complaint, the Practice agreed in this instance to offer NHS treatment to Mr X, though any continuing treatment would be subject to his adherence to the attendance policy.

Aneurin Bevan University Health Board - Clinical treatment outside hospital

Case Number: 201807636 – Report issued in April 2019

Mrs X complained that the Health Board failed to diagnose her son, giving him several diagnosis's none of which have been confirmed or treated properly. Mrs X also complained that the Health Board removed her son from the waiting list on multiple occasions and refuse to see him despite several urgent referrals

from his GP and medical assessment doctors.

The Ombudsman found that whilst the Health Board had provided informal responses to Mrs X it had not addressed her concerns under 'Putting Things Right' ("PTR"). The Health Board therefore agreed to complete the following in settlement of Mrs X's complaint without delay.

- a) Issue its PTR response

[Cardiff and Vale University Health Board - Medical records/standards of record-keeping](#)

[Case Number: 201806742 – Report issued in April 2019](#)

Mrs X complained that the Health Board lost her late father's medical records, which denied her the opportunity to have his care reviewed and left his family with enduring uncertainty about whether he received appropriate treatment.

In the absence of the relevant medical records, the Ombudsman was unable to consider the adequacy of the clinical treatment provided. This represents a significant injustice to Mrs X and her family. The Health Board agreed to:

- a) Apologise to the family for the loss of medical records.
- b) Confirm to the family that an investigation will be expedited should the records materialise in the future.
- c) Provide financial redress in the sum of £1500 to the family in recognition of the loss of opportunity to have the care complained about independently considered.

The Ombudsman considered these actions to represent an appropriate resolution to the complaint.

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

[Case Number: 201800926 – Report issued in April 2019](#)

Mr X complained to the Ombudsman about the falls that his late father suffered while an in-patient at two different hospitals within the area of Swansea Bay University Health Board formerly known as Abertawe Bro Morgannwg University Health Board ("the Health Board"). Mr X complained that these falls were preventable and occurred as a result of inadequate risk-assessments and poor observation on the part of clinicians.

Following commencement of the Ombudsman's investigation, the Health Board reviewed the care provided to Mr X's father and identified that there had been a breach of its duty of care towards him. The Health Board proposed to settle Mr X's complaint on the basis that it would undertake to:

- Invite him to engage with the redress element of the PTR process through the Health Board's Legal and Risk Services Team;
- Provide him with free legal advice in accordance with the PTR process;
- Make a payment to him of £250 in recognition of the failure of the Health Board to identify the breach of duty of care earlier in its investigation.

The Ombudsman considered this to be a reasonable settlement and concluded the investigation on the basis of the action the Health Board agreed to take.

[Cwm Taf Morgannwg University Health Board – Other](#)

[Case Number: 201807955 – Report issued in May 2019](#)

Ms X complained about her father's care, specifically the Health Board's communication with her and her family about his deterioration, that he was unlikely to survive and his medication (including responding to medication).

The Ombudsman considered that the complaint was open to early resolution because the complaints

appeared to raise new concerns and comments. The Health Board agreed to provide Ms X with a response to her outstanding concerns and to hold a meeting with her to discuss her concerns.

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

[Case Number: 201807991 – Report issued in May 2019](#)

Mr X complained about the care and treatment that was afforded to his late father, specifically the alleged misdiagnosis of a swelling on his left arm. He said the Health Board could not locate his father's medical notes relating to his admission and the procedure which he underwent on 7 April 2018. Consequently, the Health Board was unable to provide him with a fulsome response to key aspects of his concern. The Ombudsman was concerned to note that the Health Board was unable to locate the medical records and the resulting disappointment that would have been caused to Mr X. Following the Ombudsman's discussions with the Health Board, it located the medical records and agreed to carry out the following actions in settlement of Mr X's complaint:

- a) To carry out a full review of the medical records and provide Mr X with a fulsome response to the concerns raised.
- b) To provide Mr X with the written response within four weeks of the date of this letter.

The Ombudsman was satisfied that the action with the Health Board had agreed to take was reasonable and would resolve the complaint.

[Velindre University NHS Trust - Clinical treatment in hospital](#)

[Case Number: 201806215 – Report issued in May 2019](#)

Mr Q complained that Velindre University NHS Trust ("the Trust") administered him with an incorrect dose of Oxaliplatin (cancer medication) during his final course of treatment, causing him worry, stress and anxiety. The Ombudsman began an investigation and noted that the Trust had upheld Mr Q's complaint, saying that it was confident that the reduced amount of Oxaliplatin Mr Q received had not caused him any harm. The Trust had also identified areas for improvement and had begun taking action to minimise the likelihood of such instances happening again. Accordingly, the Ombudsman decided that carrying out a full investigation was unlikely to result in a different outcome to that already achieved. The Trust, however, informed the Ombudsman that Mr Q had not at any point spoken to his Consultant Oncologist following his treatment and discharge.

The Trust therefore suggested, and the Ombudsman agreed with, that by way of a settlement, Mr Q would be invited to a meeting with relevant Trust staff, including the Consultant Oncologist, so Mr Q could receive the reassurances he needed.

[Ash Grove Medical Centre - Clinical treatment outside hospital](#)

[Case Number: 201900729 – Report issued in May 2019](#)

Mr X complained that Ash Grove Medical Centre ("the Surgery") has not diagnosed his skin condition that he has been suffering with for some time. Mr X complained that there is ongoing confusion as to a way forward to treat the condition.

Mr X also complained that despite requesting a copy of his medical records from the Surgery, he is still awaiting them.

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

- a) By 7 June 2019, arrange a meeting between Mr X, the Practice Manager and the GP;
- b) By 17 May 2019, send Mr X the requested medical records.

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

Welsh Ambulance Services NHS Trust - Ambulance Services

Case Number: 201900804 - Report issued in June 2019

Mrs X complained that there had been a delay in an emergency ambulance reaching her elderly mother following a fall. In addition, the ambulance had subsequently broken down. Mrs X complained that incorrect information had been recorded by the call handlers which she felt had affected the prioritisation of the calls.

The Ombudsman found no evidence to support the concern that there was any incorrect information that affected the categorisation of the calls or the dispatch of an emergency ambulance.

However, there were two aspects of the WAST response to Mrs X's complaint which did not appear to have been fully investigated or responded to. These were:

- a) a missed opportunity to dispatch an ambulance earlier, and;
- b) the emergency ambulance breaking down.

WAST therefore agreed to undertake further investigation and to provide a full written explanation to Mrs X in respect of the two points above, and any identified learning arising from its findings. It agreed to do this by 8 July 2019.

Hywel Dda University Health Board - Clinical treatment in hospital

Case Number: 201900356 - Report issued in June 2019

Mrs X complained about the Health Board's alleged failure to acknowledge that it had provided an incorrect diagnosis in relation to Lupus and that she needed a second opinion. Mrs X also complained about the treatment which she received under the care of the Rheumatology and Dermatology departments.

Regarding Mrs X's diagnosis, the Ombudsman noted that she was in effect asking for a retrospective investigation into matters which took place in 2013, and she had become aware that the diagnosis was incorrect in April 2017. In considering these factors, the Ombudsman formed the view that this aspect of Mrs X's complaint was out of time.

The Ombudsman was however concerned to note Mrs X's ongoing concern about local service provision. Following discussions with the Health Board, it agreed to carry out the following action in resolution of Mrs X's complaint.

- a) Transfer Mrs X's care (on an exceptional basis only) to a Consultant Rheumatologist based in the Swansea area, due to her loss of confidence in the Health Board and the subsequent breakdown in the relationship that occurred.

The Ombudsman was satisfied that the action which the Health Board had agreed to take was reasonable and would resolve the complaint.

Cardiff and Vale University Health Board - Clinical treatment outside hospital

Case Number: 201807569 - Report issued in June 2019

Mrs X complained about the lack of appropriate mental health service and medical support that had been afforded to her son, KB. Mrs X said that the Health Board had previously proposed that the Vale Locality Mental Health Team would undertake several actions points, however, she complained that these actions had not been fully progressed in order to resolve her concerns.

The Ombudsman took the opportunity to discuss the complaint with the Health Board, and in doing so, it explained the action which it had newly put in place in order to settle Mrs X's complaint:

- a) Allocated a social worker as the new care coordinator, to act as the single point of contact within the team. The care coordinator would look to complete a clear and robust care plan with KB to ensure his needs are identified and suitable support options are actioned.
- b) Allocated a responsible clinician to work towards clarifying KB's diagnosis. Arrangements had been made for an outpatient appointment to take place on 17 July 2019.

The Ombudsman was satisfied that the actions which the Health Board had said it had taken was reasonable and would resolve Mrs X's complaint.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital
Case Number: 201802563 - Report issued in June 2019

Mrs A complained about unreasonable delay by the Health Board when determining her retrospective claim for NHS Continuing Health Care ("CHC") on behalf of her late mother. As a result of the delay, Mrs A found that she was too late to claim for a past period of care when her mother was in resident in England.

The Ombudsman found that the Health Board had taken five and a half year to determine that Mrs A's mother was not eligible for CHC at the time of her transfer from a hospital in Wales to a residential care home in England.

In settlement of the complaint, the Health Board took steps to ensure that Mrs A's claim was accepted for review by the relevant health care body in England. The Health Board also agreed to apologise to Mrs A and to make her a redress payment of £250 in recognition of the delay and her additional time and trouble in pursuing subsequent complaints.

Community Facilities, Recreation and Leisure

Early Resolution or Voluntary Settlement

Cardiff Council - Parks, outdoor centres and facilities
Case Number: 201900329 – Report issued in June 2019

Mr X made an initial service request to collect asbestos material in April 2015 however 4 years later it has not been collected. Mr X wrote a number of letters and recently submitted a new complaint, however received no reply.

The Ombudsman was concerned about the delays and that Mr X had not received a response. The Council accepted that this was not an acceptable service and agreed to undertake the following action, in settlement of the complaint:

- a) Provide a meaningful apology and financial redress of £150 for time and trouble (within 10 working days of the date of the Ombudsman's decision letter)
- b) Arrange for the asbestos to be collected (within one month of the date of the Ombudsman's decision letter)
- c) Consider and establish a Parks department internal complaint escalation procedure.

Complaints Handling

Upheld

Isle of Anglesey County Council - Adult Social Services

Case Number: 201705774 – Report issued in April 2019

Mr G complained that, contrary to Welsh Government guidelines, the Isle of Anglesey County Council ('the Council') declined to fully fund his choice of an alternative placement for his wife, Mrs G, when the EMI care home in which she had been residing could no longer accommodate her. Mr G complained that the Council:

- a) Engaged with the process of identifying alternative placements for Mrs G only four weeks before the change in the care home's registration, despite being aware of the need to do this for several months.
- b) Failed to re-assess or review Mrs G's care and well-being needs prior to identifying alternative care homes that it considered 'suitable'.
- c) Failed to consider how the disruption of moving to a new care home would adversely impact on Mrs G's dementia.
- d) Declined to fully fund Mr G's first choice of care home, obliging him to pay substantial top-up fees. Mr G complained that other, less expensive care homes identified by the Council did not fully meet his wife's needs.

The Ombudsman upheld complaints 1, 2 and 4. He recommended that the Council provides Mr G with a fulsome written apology for the administrative and communication failings the investigation identified and makes a payment to him of £250 in recognition of the time and trouble to which he was put in making his complaint. The Ombudsman also recommended that the Council reimburses the top-up fees that Mr G made in respect of his wife's care costs for the period under consideration.

The Ombudsman additionally recommended that the Council demonstrates that it has taken steps to refamiliarise relevant Council personnel with:

- The Council's charging policy
- Annex C (Choice of Accommodation and Additional Costs) of the Code of Practice issued to the Social Services & Wellbeing Act 2014.
- Article 8 of the ECHR and the HRA.
- The statutory requirement and importance of performing and reviewing assessments of needs and well-being.
- The importance of responding to correspondence.

The Council agreed to implement these recommendations.

Abertawe Bro Morgannwg University Health Board – Health

Case Number: 201801689 – Report issued in June 2019

Mr A complained about the care provided for his late father, Mr B, in particular about:

- a) the handover of Mr B's care from the Health Board to a neighbouring Health Board after he was discharged from hospital to a care home with Continuing Health Care funding
- b) the lack of oversight of medication
- c) the failure to provide an interpreter for key discussions
- d) the return of Mr B to the care home after a hospital admission, against the wishes of his family
- e) complaint handling.

The Ombudsman found that the handover of care, and reviews of Mr B in the meantime, were appropriate. His medication was appropriately prescribed, and reviewed on many occasions. The Ombudsman did not uphold these elements of the complaint. However, he found that an interpreter was not always provided to enable Mr B to participate in assessments of his mental capacity. He also found that the concerns raised by Mr B's family about the care home should have been relayed to the ward staff, and an investigation carried out; this might have meant Mr B not returning to the care home about which his family had concerns. The Ombudsman also found that the complaint response had been seriously delayed, was not always accurate and did not fully identify the Health Board's failings. He upheld the last three elements of Mr A's complaint.

The Ombudsman recommended the Health Board apologise to Mr A and make a small payment to him to reflect the failings in complaint handling and the distress caused to Mr A by the other failings identified. He also recommended that relevant members of staff were reminded of the need to ensure concerns expressed by family members about care homes are considered and referred appropriately.

Gwynedd Council - Children's Social Services

Case Number: 201801474 – Report issued in June 2019

Mr & Mrs A complained about the way in which Gwynedd Council ("the Council") had dealt with, and acted upon, the Stage 2 investigation report into their concerns. An external person conducts the Stage 2 investigation. The substance of their complaint to the Council was about a lack of service provision for their son X (17 years old at the time), who suffers from a form of Autism. Mr & Mrs A felt the Council had tried to influence the investigator into changing her report, resulting in a third (final) version finally being sent to them some months after the investigation began. The investigator found failings on the part of the Council, and made recommendations, but the Council had refused to accept them in its formal complaint response to Mr & Mrs A. This, they said, questioned the independent nature of the Stage 2 process.

The Ombudsman's investigation considered the law relating to Stage 2 investigations as well as the documents provided. He found that there had been an unreasonable delay in the Council formally responding to Mr & Mrs A's complaint, and that what had happened was unusual in such matters. The Council's actions gave at least the perception that it was seeking to influence the outcome of the investigation. When it later declined to accept its recommendations, the Council failed to give any cogent reasons for doing so. In light of other events that happened, its decision was illogical. The Ombudsman also found communication failings on the part of the Council, and that a key policy required revision in light of changes in the law. He made the following recommendations, which the Council agreed to implement in full:

- a) An apology to Mr & Mrs A, together with an offer of redress (in the total sum of £500).
- b) A review of the relevant policy to ensure its criteria aligned with the definition of 'disability' set out in both the Social Services and Wellbeing (Wales) Act 2014 and the Equality Act 2010, and ensure staff were updated about such changes.
- c) To seek specialist input to develop a plan for dealing with future assessment and support requests from /for those suffering with Autism.

Betsi Cadwaladr University Health Board - Health

Case Number: 201800189 – Report issued in June 2019

Mrs X complained that the Health Board failed to handle her concerns in an effective and timely manner, which detrimentally affected her health (through stress, anxiety and delayed treatment for her condition). Due to the more recent unavailability of family members to help with transport, Mrs X felt the Health Board should have funded any travel and accommodation costs incurred, while she attended hypnotherapy sessions, in recognition of the delays and poor complaint handling.

Mrs X was aggrieved that she had not received an adequate explanation of why the Health Board had not

received a funding request for hypnotherapy treatment, and why no one acted upon enquiries from the GP or her letter of 5 June 2017, when it was clear that the matter had been missed.

The investigation found that there had been an inordinate delay on the part of the Health Board in making the appropriate enquiries and providing a response to Mrs X's ongoing concerns. The delay in responding amounted to maladministration and was likely to have contributed to additional stress and anxiety for Mrs X, and also delayed the funding request.

The investigation also found that there had been a delay of a year in progressing the funding request and, as a result, the hypnotherapy treatment.

Both complaints were **upheld**. The Health Board agreed to apologise and make a payment of £750 to Mrs X. It also agreed to undertake relevant procedural reviews.

Early Resolution or Voluntary Settlement

Aneurin Bevan University Health Board - Health

Case Number: 201806989 – Report issued in April 2019

Mrs A complained that, following several meetings with the Health Board regarding the treatment it provided to her late mother, the outstanding questions she had remained unanswered by the Health Board. Mrs A also complained that it had failed to provide a copy of her mother's medical records ("the records") to her.

In responding to the Ombudsman's enquiries, the Health Board confirmed that its complaint response was due to be issued imminently. It also said that, despite searching for the records, it had been unable to locate them.

The Health Board therefore agreed to complete the following actions by 30 May 2019 in settlement of Mrs A's complaint:

- a) Issue its complaint response
- b) Apologise for the missing records
- c) Make a payment of £250 to Mrs A in recognition of the lost records
- d) Issue the records to Mrs A promptly if/when they are found.

Abertawe Bro Morgannwg University Health Board – Health

Case Number: 201807225 – Report issued in April 2019

Mrs X complained that the Health Board had misinformed her about the treatment it had provided to her husband, Mr X, during his attendance at an Emergency Department. In particular, Mrs X did not agree with the Health Board's complaint response which stated that her husband had diarrhoea whilst in hospital.

The Health Board was unable to provide a copy of Mr X's medical records which referred to diarrhoea. It therefore offered to complete the following actions by 17 May 2019 in settlement of Mrs X's complaint:

- a) Apologise for the reference to diarrhoea in its complaint response
- b) Provide an explanation for the reference to diarrhoea
- c) Make a payment of £250 to Mr and Mrs X in recognition of its poor handling of the complaint.

Rhondda Cynon Taf County Borough Council – Roads and Transport

Case Number: 201807891 - Report issued in April 2019

Ms X complained that the Council had failed to respond to her correspondence about a car parking Penalty Charge Notice she had received.

The Council confirmed to the Ombudsman that, due to an oversight, it had failed to respond to Ms X. The Council therefore agreed to complete the following by 3 May 2019 in settlement of Ms X's complaint:

- a) Apologise to Ms X for failing to respond to her correspondence
- b) Explain why it failed to respond
- c) Provide a response to Ms X's correspondence.

Cardiff Council - Roads and Transport

Case Number: 201807919 - Report issued in April 2019

Mr B complained that the Council had failed to resolve his complaint about a Bus Lane Penalty Charge Notice he had received.

The Council informed the Ombudsman that Mr B's emails of complaint had been received, but had been caught in its email spam filters.

The Council therefore offered to undertake the following by 3 May 2019 in settlement of Mr B's complaint:

- a) Apologise to Mr B for failing to respond to his correspondence
- b) Provide a response to Mr B's concerns
- c) Offer a payment of £50 to Mr B for the time and trouble in making his complaint to the Ombudsman.

Betsi Cadwaladr University Health Board - Health

Case Number: 201900349 - Report issued in April 2019

Mrs S complained that Betsi Cadwaladr University Health Board ("the Health Board") had not responded to the complaint she made to it in September 2018 regarding the treatment she received when she was a patient at Glan Clwyd Hospital.

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

- a) To issue a response letter addressing Mrs S's concerns by 14 May 2019.

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

Aneurin Bevan University Health Board - Complaints Handling

Case Number: 201806438 - Report issued in April 2019

Ms X complained that the Health Board has been unprofessional and untimely in responding to a complaint she raised in August 2017. A letter was received in December 2018 confirming that the matter was to go to the Health Board's Redress Panel in February 2019.

The Health Board confirmed the reasons for the delay in concluding Ms X's complaint and agreed with the Ombudsman to undertake the following in settlement of it:

1. Write a formal apology to Ms X for the delay, **by 29 March 2019**.
2. Offer a redress payment of £100 for the time and trouble in pursuing the complaint, **by 29 March 2019**.

Cardiff Council - Children's Social Services

Case Number 201807568 - Report issued in April 2019

Mrs X complained that following a previous complaint she made to the Ombudsman, whilst the agreed settlement actions had been undertaken by the Council, she has not continued to receive financial assistance in relation to her niece's continued placement with her. Mrs X has contacted the Council regarding this and requested a breakdown of the previous financial assistance she received. However, despite contacting the Council, the Council has not responded to her request.

The Ombudsman contacted the Council as the evidence suggested that Mrs X ought to have been provided with financial assistance and it had failed to respond to her request for information. It agreed to carry out the following, within 6 weeks of the decision letter, in settlement of the complaint:

- a) To provide an apology to Mrs X for the failure to keep her informed and for failing to respond to her requests
- b) To provide Mrs X with the breakdown of the backdated payment she has already received
- c) To provide an explanation to Mrs X as to why the decision was made to not make ongoing payments following the Ombudsman's original decision
- d) To calculate the amount of financial assistance due to Mrs X and provide her with this backdated payment
- e) To commit to continuing to provide Mrs X with financial assistance until her niece reaches 18 years old if she continues to live with Mrs X.

Hywel Dda University Health Board – Health

Case Number: 201900795 – Report issued in May 2019

Mrs X complained that the Health Board failed to provide a complaint response to her complaint, which was made to it on 1 May 2018.

The Ombudsman found that the Health Board had failed to provide a PTR response in relation to Mrs X's complaint. The Health Board therefore agreed to complete the following in settlement of the complaint by 6 June 2019.

- a) Provide a written letter of apology for the delay in providing a PTR response to Mrs X
- b) Issue a PTR response in relation to Mrs X's complaint
- c) Pay Mrs X a sum of £125 in recognition of the time and trouble in pursuing her complaint.

Northgate - Various Other

Case Number: 201900462 – Report issued in May 2019

Mrs X complained that following complaint emails sent to Northgate, it did not provide a response and failed to resolve her complaint regarding a washing machine that her daughter was granted through the Discretionary Assistance Fund.

The Ombudsman found that Northgate had failed to provide a written response to Mrs X following her complaint. Northgate therefore suggested it complete the following in settlement of Mrs X's complaint.

- a) Provide a written apology to Mrs X for the delay in providing a response
- b) provide assurance to Mrs X that, it will commit to consider preventative measures to
- a) prevent this happening in the future
- c) provide Mrs X with a direct BACS payment to the value of £500. This payment will cover the value of the original item, delivery, installation, waste pipe extension and an element of recompense for time assigned to making a complaint.

Powys County Council – Children's Social Services

Case Number: 201708002 – Report issued in May 2019

Mr X complained that the Council had refused to investigate his complaint in accordance with its Social Services complaints procedure as there was ongoing legal action. Mr X said that the legal action was unrelated to the complaint he had made.

Further to the Ombudsman's enquiries, the Council agreed to undertake the following actions by 6 June

2019 in settlement of Mr X's complaint:

- a) Apologise for the delay it caused in refusing to consider Mr X's complaint
- b) Issue its response at Stage 1 of its Social Services complaints procedure.

Cardiff and Vale University Health Board - Health

Case Number: 201900732 – Report issued in June 2019

Mrs G raised concerns with the Health Board about the care provided to her daughter by her GP Practice. However, Mrs G said that the Health Board had not dealt with her complaint properly because it had simply referred her concerns back to the GP Practice to investigate.

The Ombudsman found that, whilst it was open for the Health Board to refer a complaint about a GP Practice back to that body to respond, it had decided to investigate Mrs G's concerns itself. However, conflicting and, at times, incorrect information was given to Mrs G about the process the Health Board was following. The final response enclosed statements from the GP practice, but failed to provide any meaningful information about the steps the Health Board had taken during the investigation or the evidence which was considered. Furthermore, there was no explanation of what conclusions the Health Board had drawn or on what basis it had found the GP's responses to be robust.

The Health Board agreed to apologise to Mrs G and to offer her £250 redress in recognition of the additional frustration and confusion resulting from the failure to manage Mrs G's expectations appropriately. It also agreed to remind all complaints handling staff involved in this case of the Health Board's duty, when it decides to investigate a complaint about a Primary Care Provider (such as a GP), to carry out the investigation and issue the response in line with the regulations which cover the NHS process for complaint handling ("Putting things Right").

Caerphilly County Borough Council - Adult Social Services

Case Number: 201901558 – Report issued in June 2019

Mr X complained that the Council failed to respond to the complaint about his mother's transfer from hospital to a Care Home which the Ombudsman referred to it in January 2019. Mr X also complained about the way in which he had been pursued for Care Home fees.

The Ombudsman found that the Council required further information from Mr X about his complaint and there had subsequently been a misunderstanding in which Mr X and the Council were awaiting further correspondence from one another.

The Council therefore agreed to complete the following actions in settlement of Mr X's complaint:

By 25 July 2019:

- a) Arrange a mutually convenient date for a meeting with Mr X to discuss his concerns

Within ten working days of the meeting:

- b) Advise Mr X in writing whether his concerns will be dealt with under the Council's Protection of Vulnerable Adults procedure or its Social Services complaints procedure.

Neath Port Talbot Council - Environment and Environmental Health

Case Number: 201901451 – Report issued in June 2019

Mrs B complained that the Council failed to respond to her complaint about a neighbouring empty property, and did not respond to her earlier Freedom of Information ("FOI") requests related to the property.

In settlement of the complaint, the Council agreed to complete the following actions by 12 July 2019:

- a) Apologise for the poor handling of Mrs B's FOI requests and for failing to respond to the complaint made by Mrs B in
- b) February 2019
- c) Provide an FOI response and a copy of its FOI complaints procedure to Mrs B
- d) Issue a response to the complaint under stage 2 of its complaint procedure
- e) Make a payment of £50 to Mrs B for its communication failings and for her time and trouble in making a complaint to the Ombudsman.

Education

Upheld

Wrexham County Borough Council - School Transport

Case Number: 201900836 – Report issued in May 2019

Ms A complained that the Council did not take its decision to refuse to provide free school transport for her child properly.

The Ombudsman upheld the complaint to a limited extent. He found that the guidance was not clear on how it would calculate the closest school when there were no non-hazardous walking routes available and it had not given clear information to Ms A on how it had applied its policy in her case, which caused her some concern. The Ombudsman also found that the Council had provided information to Ms A which led her to believe it had not properly calculated the distance, which led to further confusion. However, ultimately it was established that there was no evidence of maladministration in the way the Council had made the decision.

The Council has agreed to consider amending the policy to clarify how it calculates the nearest suitable school when there are no non-hazardous routes available to the relevant schools. The Council also agreed to apologise to Ms A for the way it dealt with the concerns she raised.

Denbighshire County Council - Special Educational Needs (SEN)

Case Number: 201701203 – Report issued in May 2019

Mrs X complained that, between September 2015 and September 2016, the Council failed to consider carrying out an assessment of her child, B's, special educational needs ("SEN") or inform her that she could request an assessment of B's SEN. Mrs X also complained that, in April 2017, the Council did not complete an assessment of B's SEN within a five-week timescale and that its decision not to issue a statement for B in July 2017 was discriminatory.

The Ombudsman acknowledged that this was a complex and detailed case and one which Council staff members had spent a significant amount of time on. However, he concluded that the Council's failure to be able to produce documented evidence of consideration of an assessment of B between September 2015 and September 2016, and its failure to properly communicate these reasons to Mrs X, amounted to maladministration. He upheld this complaint.

The Ombudsman did not consider that the Council's service level agreement with a support agency fully met its responsibility to empower parents to have detailed knowledge of their child's entitlement in relation to SEN legislation. He upheld this complaint to the extent that the Council should have informed Mrs X about her ability to request an assessment herself and directed her to the information regarding this matter on its website.

The Ombudsman upheld Mrs X's complaint that an assessment should have been carried out within five weeks and was not. The Ombudsman is not able to determine complaints of discrimination; that is a matter for the courts. However, he suggested that the Council considers reflecting on this case and the language it used in its correspondence to Mrs X.

The Council agreed to apologise to Mrs X and make a redress payment of £250 redress payment for the shortcomings identified. He also recommended that:

- a) the Council provide additional information to its communication with parents and guardians about their SEN entitlements, and
- b) use a robust system to record, at appropriate stages, what interventions the Council would consider necessary to meet a child 's SEN, or why it considers an assessment to be unnecessary.

Early Resolution or Voluntary Settlement

Newport City Council - Education

Case Number: 201900426– Report issued in May 2019

Mr X complained that the Council failed to respond to the concerns he raised regarding his son's education, in line with its set time frames, and that it failed to respond to emails and return phone calls. The Council acknowledged its failing to investigate Mr X's complaint in line with its complaints procedure. It also acknowledged that it did not have a clear understanding of the complaint. It therefore agreed to undertake the following in settlement of the complaint: -

1. Make all necessary arrangements to obtain a clear understanding of the complaint(s).

Carryout a formal complaints investigation and issue a response to Mr X **by 3 June 2019**.

Neath Port Talbot Council - School Transport

Case Number: 201900330 – Report issued in June 2019

Mrs A's complaint relates to the Council's, and its School Transport Appeals Panel's ("the Panel"), decision not to provide free school transport to her daughter, B, because she lives less than two miles from the primary school ("the School") her daughter attends. Mrs A said that her daughter's disability means she cannot walk safely to the School, the impact of Mrs A's epilepsy prevents her from safely accompanying her daughter to the School, and the decision for her daughter to attend the School was not one of parental choice but because the School is named in her daughter's special educational needs statement ("SEN") as being appropriate to meet her specific educational needs arising from B's disability.

The Council is required under section 24 (a) of the Learner Wales Travel Measure 2008 to have specific regard to the needs of a disabled learner and learners with learning difficulties and the nature of the route the child is expected to take between home and school must be considered in that light.

The Ombudsman contacted the Council and it agreed to convene a fresh Panel to consider Mrs A's request for B to be provided with free home to school transport to attend the School with specific regard to B's individual and specific needs, the School is named in B's SEN statement and the individual circumstances and availability of a safe walking route to the School in view of the impact of Mrs A's disability.

Environment and Environmental Health

Early Resolution or Voluntary Settlement

Cardiff Council - Other

Case Number: 201807089 - Report issued in April 2019

Mr X complained about a Council employees behaviour and their management of its caravan site including health and safety, access and maintenance at the site. Mr X felt that the Council had not taken his complaint seriously and did not investigate it appropriately.

The Ombudsman considered that some aspects of Mr X's complaint fell outside of his jurisdiction, however, was concerned about the management of the complaint and the detail of the investigation. The Ombudsman considered that this was indicative of poor complaint handling. The Council agreed to apologise to Mr X, provide him with a suitable response in accordance with its policies, provide a response to his outstanding queries and if he was agreeable to meet and discuss the complaint.

Housing

Not Upheld

Cardiff Council - Group or block repair/improvement grants (NOT DFGs)

Case Number: 201706285 & 201706284 & 201706283 – Report issued in May 2019

Ms Y complained about the inadequate action taken by Cardiff Council ("the Council") in response to her complaint about ongoing issues arising at her property because of her participation in the ARBED scheme (the Welsh Government's strategic energy performance investment programme). In particular, she said that no complaints procedure was evident and therefore she presented her complaint to many people and numerous bodies.

The investigation found that the Council had not acted unreasonably in respect of this matter. The way in which the Council responded to the concerns raised was consistent with its Complaints Policy and the Memorandum of Understanding it had with a Housing Association for the delivery of the scheme. The investigation found that the Council had not been responsible for any unreasonable delay in seeking to address Ms Y's concerns. The Council's position in respect of the remedy offered to Ms Y was informed by the professional opinion of an independent expert. The investigation did not find evidence of maladministration on the part of the Council in this matter. The complaint was **not upheld**.

Cardiff Council - Group or block repair/improvement grants (NOT DFGs)

Case Number: 201706284– Report issued in May 2019

Ms B complained about the inadequate action taken by Cardiff Council ("the Council") in response to her complaint about ongoing issues arising at her property because of her participation in the ARBED scheme. In particular, she said that no complaints procedure was evident and that responses to her complaints were erratic (in terms of timeliness) and contradictory.

The investigation found that the Council had not acted unreasonably in respect of this matter. The way in which the Council responded to the concerns raised was consistent with its Complaints Policy and the Memorandum of Understanding it had with a Housing Association for the delivery of the scheme. The investigation found that the Council had not been responsible for any unreasonable delay in seeking to address Ms B's concerns. The Council's position in respect of the remedy offered to Ms B was informed by the professional opinion of an independent expert. The investigation did not find evidence of maladministration on the part of the Council in this matter. The complaint was **not upheld**.

Early Resolution or Voluntary Settlement

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

Case number: 201807620 - Report published in April 2019

Mr X complained to the Ombudsman that the Housing Association had reached a decision on his request

for an adaptation at his property (the provision of a downstairs toilet) without a current Occupational Therapist assessment.

The Ombudsman found that although the Housing Association suggested in a response letter that it had assessed for a downstairs toilet, they could not provide further information other than an Occupational Therapist report from two years ago which related to an upstairs bathroom at the property.

The Housing Association agreed to undertake the following actions, in settlement of the complaint:

- (a) Carry out an up to date Occupational Therapist assessment of Mr X's health conditions and the adaptations he is requesting.

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

Case number: 201806589 - Report published in April 2019

Mr X, a tenant of Trivallis, made several complaints about the service provided to him. In particular, he complained that Trivallis had not dealt with his complaints of noise and anti-social behaviour (ASB) in accordance with its policy. He also complained that Trivallis had not addressed issues raised about the safety of the garden of his property (and others) nor had it carried out previously agreed works to the garden.

Trivallis acknowledged that there had been some shortcomings in its handling of the above issues. It therefore agreed to:

- Provide a written update to the Ombudsman (**within three months**) about both:
 - (a) The action taken in response to Mr X's noise and ASB complaints; and
 - (b) The action taken to address the safety of the gardens at affected properties and a timescale for the completion of the previously agreed works to Mr X's garden.
- Complete a review of the circumstances of Mr X's complaint (**by 17 May**) covering:
 - a) The reasons for the previous lack of action on Mr X's ASB complaint;
 - b) The delay in resolving the issues concerning the garden(s);
 - c) The complaints handling process;
 - d) Consideration of any learning points and customer service/communication improvements identified;
 - e) Consideration of an apology and financial redress for Mr X for any identified failings.

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

Swansea Council - Tenancy rights and conditions/abandonment and evictions

Case Number: 201901362 – Report issued in June 2019

Ms X complained that the Council charged an additional rental charge due to a late return of keys. Ms X said she had tried to return the keys on two occasions and that they had not been accepted until her third visit, which was five days after the deadline for return.

The Council agreed with the Ombudsman to waive the additional charge under the circumstances.

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

Case Number: 201808021– Report issued in June 2019

Ms B complained that the Council had failed to undertake housing repair work related to damp and plastering issues.

The Ombudsman found that there had not been a recent inspection of Ms B's property to consider such issues. The Council therefore agreed to complete the following actions in settlement of Ms B's complaint:

- a) Send an appropriate Officer to Ms B's property **by 3 July 2019** to inspect the walls for damp and/or plastering damage
- b) Write to Ms B **within 15 working days** of its inspection to confirm whether repair work is required.

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

[Case Number: 201901180 – Report issued in June 2019](#)

Ms M complained that the Association had failed to advise her that she would not have an outside toilet and separate storage shed at the property she was moving into. She stated that the Occupational Therapy Assessment she had undertaken had been based on her being able to use the outside toilet at the property.

The Ombudsman was of the view that the information provided to Mrs M appeared to have caused confusion. It suggested that the Association should carry out the following actions as an early voluntary resolution to her complaint.

It was agreed that the Association would:

- a) provide Ms M with a small storage shed to accommodate gardening equipment and tools. This would free up space for her to use the outside toilet that is located at the property.

The above agreed resolution will be completed within 20 working days of the date of this letter. The Ombudsman believes that this provides a resolution to this complaint.

Planning and Building Control

Upheld

[Carmarthenshire County Council - Other planning matters](#)

[Case Number: 201705594 - Report issued in June 2019](#)

Mr X complained that the Council mishandled the investigation of a high hedge complaint relating to his land. He complained that the Council unreasonably refused to withdraw the remedial notice despite both major parties to the dispute requesting its withdrawal and the Council's own complaint investigation report recommending its withdrawal. Mr X was aggrieved that the Council refused to explain why it had a right to introduce an element to the high hedge complaint which had not been referred to by the complainant and to judge the complaint on that one issue.

The investigation found that although there was a delay in providing Mr X with the calculations used to justify issuing a remedial notice and that the decision letter regarding the remedial notice could have been clearer and more thorough, there was no compelling evidence of predetermination or procedural unfairness. This aspect of the complaint was **not upheld**. The investigation found that whilst it had been reasonable for the Council not to determine the purported application for the notice to be withdrawn, because the application had lacked the necessary details, it had not communicated the reasons for this clearly. This amounted to

maladministration which caused a delay in progressing the intended application. This aspect of the complaint was **upheld**. The investigation found that the way in which the Council had considered the high hedge complaint, in terms of the grounds of complaint, had been reasonable. This aspect of the complaint was **not upheld**.

The Council agreed to apologise for the failings found, to make a time and trouble payment of £250 to Mr X, to set out clearly what was required for the application to withdraw the notice to be determined and to determine such an application in a timely manner, and to consider introducing a suitable template letter or information leaflet regarding the options available to withdraw or relax the requirements of a remedial notice.

Early Resolution or Voluntary Settlement

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

Case Number: 201901018 & 201901019 - Report issued in June 2019

Mr A complained on behalf of Mr B about the Council's lack of response to the complaint about its failure to take formal enforcement action against the erection of a fence.

The Ombudsman contacted the Council as he was concerned that despite referring the matter back to the Council for consideration under its formal complaints policy in February, a response had not been received. He was also concerned about the lack of communication. The Council agreed to carry out the following in settlement of the complaint:

- a) to apologise for the delayed response and to fully explain the reasons for the delay
- b) to provide a comprehensive response to the complaint within an urgent defined timescale.

Roads and Transport

Upheld

Isle of Anglesey County Council - Parking

Case Number: 201707282 - Report issued in April 2019

Mrs A complained on behalf of herself and her elderly neighbours, all of whom live in designated senior citizen bungalows, about Isle of Anglesey County Council's ("the Council") failure to deliver a proposed scheme to provide dedicated parking spaces for them. Mrs A referred to her and the affected residents' varying health concerns and the difficulties not having dedicated parking caused.

The Ombudsman's investigation found that the Council's consideration of Mrs A's case was unduly blinkered in that it focused only on the affected residents' request for parking and failed to recognise that its wider public sector duties were potentially engaged including around homelessness and equality. He also identified that the Council's complaint handling in this case was not sufficiently robust. The Ombudsman upheld Mrs A's complaint to that extent. Amongst the recommendations he agreed with the Council were that the Council should apologise to Mrs A and the other affected residents for the failings identified and write offering to carry out appropriate assessments of their needs.

Early Resolution or Voluntary Settlement

Flintshire County Council – Parking

Case Number: 201901232 - Report issued in June 2019

Mr P complained that the Council had failed to install parking restrictions which it agreed to install in 2018, and had not responded to his complaint.

The Council informed the Ombudsman that a complaint had been received from Mr P in June 2018, and it would have issued its response to him by August 2018 under the first stage of its two-stage complaints

procedure.

However, as the Council had implemented a new complaints system, it was not able to provide the Ombudsman with a copy of its Stage One complaint response to Mr P.

Therefore, in settlement of the complaint, the Council agreed to issue a Stage Two complaint response to Mr P by 4 July 2019, which clearly outlines its position regarding the parking restriction works.

Social Services – Adult

Upheld

Carmarthenshire County Council - Other

Case Number: 201801687 – Report issued in June 2019

Ms K complained about Carmarthenshire County Council's ("the Council") protracted delay in concluding its safeguarding investigation following a referral made against her and the impact this delay had on her. The Ombudsman's investigation found that when the Council began its investigation, guided by the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2010) ("the POVA Policy"), it did not adhere to the timescales set out in the POVA Policy, and the amount of time it took to complete the investigation (over a year) was excessive. The Council argued that it was a complex historic case, the risk level was low and high-risk investigations took priority. Whilst the Ombudsman acknowledged those reasons, he pointed out that the POVA Policy did not differentiate between safeguarding referrals, nor did it assign priority to high or low-risk referrals. The Ombudsman also highlighted that the Council did follow certain parts of the POVA Policy, but by not following others, its actions amounted to maladministration.

The Ombudsman did, however, acknowledge that the Council would still have upheld the allegation against Ms K even if it had completed its investigation within a reasonable timeframe. Because of this, the injustice to Ms K was great but not significant.

The Ombudsman upheld Ms K's complaint and recommended that the Council apologise to Ms K for the delay, pay her financial redress totalling £500 and share the findings of the report with safeguarding staff to ensure lessons were learned.

Early Resolution or Voluntary Settlement

Swansea Council – Services for vulnerable adults (eg with learning difficulties, or with mental health issues)

Case Number: 201807487 - Report issued in April 2019

Mr X requested that his Stage 1 complaint response under the Council's social services complaints procedure to be escalated to Stage 2 of the procedure. The Council's letter dated 1 February 2019 declined his request.

The Ombudsman considered that it would have been appropriate for the Council to undertake a Stage 2 investigation under prevailing legislation.

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

- a) Carry out a Stage 2 Investigation under the Social Services complaint procedure.

Pembrokeshire County Council - Other

Case Number: 201900872 – Report issued in June 2019

Ms X complained that Pembrokeshire County Council ("the Council") provided her with misleading information about her mother's entitlement to respite care. Following a stage 2 complaint investigation, an independent investigator said that the Council's systems needed to be updated to ensure that correct information was given to care users. Ms X said that, despite the Council agreeing that her mother did not have to pay for her respite care in 2019, Ms X had paid a contribution towards it. She was also unhappy with the limited apology she had been given following the stage 2 report.

The Council agreed to take the following action to resolve the complaint, which the Ombudsman considered to be reasonable:

- a) Update its computer systems no later than 22 July 2019 to ensure that correct information was given to service users regarding care funding.
- b) Refund Ms X the contribution she paid towards her mother's respite care in 2019.
- c) Write to Ms X with a personal apology from a senior member of Social Services staff to recognise and apologise for the stress that the issues raised in her complaint caused.

Social Services – Children

Early Resolution or Voluntary Settlement

Powys County Council - Children in care/taken into care/'at risk' register/child abuse/custody of children
Case Number: 201806654 - Report issued in April 2019

The Ombudsman received a complaint from Mrs W saying that Powys County Council ("the Council") failed to implement an independent investigator's recommendations following an investigation under the Social Services Complaints Procedure (Wales) Regulations 2014.

The Ombudsman found that the Council had not yet had the opportunity to provide Mrs W with this information, therefore, the Council agreed to undertake the following proposals within 30 days:

- a) To provide Mrs W with a comprehensive and detailed response, which covers all the issues raised in recent correspondence
- b) Without further delay to provide Mrs W with any further information about the process or outcome of the Section 47 which you have not yet received
- c) To provide Mrs W and her family with a meaningful apology in respect of how the investigation was conducted

Pembrokeshire County Council - Other

Case Number: 201807215 - Report issued in April 2019

Mrs M complained that the Council had failed to investigate her complaint at stage One of its complaint procedure. She had complained to it regarding the failure of social services to deal with her daughter's supervision and proposed care of her unborn child.

The Ombudsman considered her complaint and was of the opinion that the complaint investigation was inadequate. It approached the Council who agreed to:

- (a) Carry out an investigation at Stage One of its complaint procedure

and

- (b) Write a letter of response to the complainant providing the outcome of its investigation at that stage

This will be completed within 20 working days of the date of my decision letter.

The Ombudsman is satisfied that this will resolve the issues complained of at this time.

Rhondda Cynon Taf County Borough Council - Children in care/taken into care/'at risk' register/child abuse/custody of children

Case Number: 201807627 - Report issued in April 2019

Ms X complained that the Council failed to help her gain legal custody for her granddaughter who had been placed in her care for being neglected by the mother, Ms X's daughter. Ms X complained that the Council took no action when her daughter took back her child, after two and a half years in Ms X's care. Since receiving the complaint, circumstances had changed and Ms X understood that the Council could take no action to help her. However, as the complaint was received by the Council in December 2018, it agreed to undertake the following actions: -

- a) Write a formal apology and explanation of the current position **by 22 May 2019**.
- b) Explain in writing the actions the Council **would** have taken to support a fresh application, had the circumstances not have changed, **by 22 May 2019**.
- c) Explain in writing the reasons why the Council can no longer take that action, due to the change of circumstances, **by 22 May 2019**.

Pembrokeshire County Council – Other

Case Number: 201806294 – Report issued in June 2019

Ms A complained about the action taken by Pembrokeshire County Council in relation to her grandchild. She raised specific concerns about its apparent failure to follow the All Wales Child Protection Procedures, the conduct of its Social Workers, its communication with another local authority and its response to her complaints about those issues. She also indicated that she was dissatisfied because the Council had not addressed her concern about a council tax rebate.

The Ombudsman found that the Council had not investigated the Social Services-related aspect of Ms A's complaint in accordance with Stage Two of its Social Services complaints process ("the Stage Two process"). He also noted that the position regarding Ms A's council tax rebate was unclear. He asked the Council if it would be willing to resolve Ms A's complaint by:

- a) Agreeing a summary of the Social Services-related issues ("the issues") that Ms A had raised, which could be investigated in accordance with the Stage Two process, with Ms A and an Independent Investigator.
- b) Writing to Ms A, after seeking input from the Independent Investigator, to explain why it does not consider it possible, if this is the case, to investigate certain elements of her complaint by way of the Stage Two process.
- c) Investigating the agreed summary of the issues that Ms A had raised in accordance with the Stage Two process.
- d) Writing to Ms A to clarify the current position in relation to her concern that it had not given her a council tax rebate.

The Council agreed to undertake these actions. The Ombudsman considered, as a consequence, that Ms A's complaint had been settled.

Rhondda Cynon Taf County Borough Council - Children in care/taken into care/'at risk' register/child abuse/custody of children

Case Number: 201807835 – Report issued in June 2019

Mrs B complained about:

- a) The decisions/actions of the social services department in relation to the removal of her newborn baby.
- b) Social workers' preparation for/participation in case conferences.
- c) Lack of support/provision.
- d)

Following commencement of the Ombudsman's investigation, the Council proposed to undertake the following in settlement of the complaint:

- a) Progress Mrs B's complaint to Stage 2 of the Social Services Complaints Procedure.
- b) Hold a learning event to share learning from the case with all relevant staff within Children's Services.
- c) Provide a report on the findings with a detailed action plan for learning and improvements identified.
- d) Offer Mrs B a full and unreserved apology for any failings identified and any distress caused.
- e) Increase the offer of financial compensation for out of pocket expenses, and in acknowledgement of the time and inconvenience of Mrs B having to pursue complaint with the Ombudsman, to £1000.

The Ombudsman considered this to be a reasonable settlement and concluded the investigation on this basis.

Various Other

Upheld

[Ammanford Town Council - Poor/No communication or failure to provide information](#)

[Case Number: 201801053 - Report issued in April 2019](#)

Mr X complained that the Council failed to publish minutes of its meetings or its complaints policy. The Ombudsman found that the Council had not published minutes of its meetings and it did not have a complaints policy. The Council agreed to implement the Ombudsman's recommendations to make a redress payment of £250 to Mr X, to adopt a complaints policy in line with the Welsh Government's Model Concerns and Complaints Policy and Guidance which is also included on its website, and to apologise that it has only recently published minutes and a complaints policy.

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

[Case Number: 201700762 – Report issued in May 2019](#)

Mr A and Miss B (tenants of the Housing Association) complained about the repair and maintenance service received from their landlord; in particular about the removal of asbestos found at their home. They were concerned about the time taken to complete repairs and worried about the risk to their health from the asbestos.

On reviewing the documentation, the Ombudsman was satisfied that there was no evidence to show that the Housing Association had failed to complete the repairs noted within a reasonable time or within relevant timescales. In relation to the asbestos, the evidence showed that some did not require removal by a licensed contractor (and so was not harmful). The remainder was removed in accordance with good practice by an appropriately qualified and licensed asbestos contractor, within the appropriate timescales. The complaint was not upheld. However, the Ombudsman noted a communication failing by the Housing Association in that it had failed to provide Mr A and Miss B with a relevant information document concerning asbestos, in accordance with its policy. Had it done, this could have avoided the misunderstanding about asbestos removal that led to the complaint. The Housing Association agreed to undertake the following

recommendations (within one month):

- a) Provide a written apology to Mr A and Miss B for the communication failing identified.
- b) Remind relevant staff of the importance of providing adequate written information to tenants when asbestos removal work is to be undertaken.

Early Resolution or Voluntary Settlement

Welsh Ambulance Services NHS Trust - Recruitment and appointment procedures

Case Number: 201900923 – Report issued in May 2019

Mr X complained that WAST failed to interact with him when he made a complaint regarding its recruitment process.

The Ombudsman found that WAST had failed to consider Mr X's complaint under PTR. WAST therefore agreed to complete the following in settlement of Mr X's complaint by 11 July 2019.

- a) Provide Mr X with an apology for failing to consider his complaint under PTR and provide an explanation for this oversight
- b) Issue a PTR response
- c) Provide Mr X with assurances that processes will be reviewed to ensure this does not happen in the future.

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