

The Ombudsman's Casebook

Issue 34 July - October 2018

News

Strategic Plan Sounding Board

In September, the Ombudsman hosted two sounding boards for public bodies and service users.

These were held to help shape the Ombudsman's next three-year strategic plan which is due to be published in April 2019. Thank you to all the organisations who took part.

Ombudsman Committee Appearances

The Ombudsman appeared in front of the Assembly Public Accounts and Finance Committees as his 2017/18 annual report and accounts and financial estimate for the forthcoming year were scrutinised.



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Section 22

The following summary relates to public interest reports issued under Section 22 of the Public Services Ombudsman (Wales) Act 2005.

Wrexham County Borough Council – Finance and Taxation
Case number 201708129 – Report issued in July 2018

Mr D had previously (in 2014, 2015 and 2016) contacted Wrexham County Borough Council (“the Council”) about Welsh language errors in the Council Tax bills he had received. In 2017, after again receiving a bill containing language errors, Mr D complained formally to the Council and then to the Ombudsman. The Ombudsman felt that he could resolve the dispute by using his powers under s 3 of the Act which enables him to resolve complaints early as opposed to undertaking a full investigation. To this end, on 3 October 2017, the Council formally agreed to apologise in writing to Mr D for the deficiencies in the Welsh language, to pay him redress of £50 for his trouble, and to give an assurance that those errors would be rectified in time for the 2018/2019 billing period (if not before).

Mr D received a bill for 2018/2019 in March 2018. He noticed that there were again a number of Welsh language errors (and inconsistency between Welsh and English within the document). He complained to the Ombudsman that the Council had failed to comply with his recommendations after all, and that it was a sign of “disrespect to tax payers, the Welsh language, the law and the Ombudsman.”

After seeing the evidence, the Ombudsman decided that he was not satisfied that the Council had implemented the recommendations in full as had been agreed. He determined that he would need to invoke his powers to issue a special report in order to convey the message to other public bodies that early resolutions under the Act are serious matters. Bodies are required to comply with them having agreed. The report was critical of the Council’s failure to implement the recommendations in full despite the Council formally agreeing to do so, and that it was only now working towards making the necessary changes for the next tax year. Given the Council uses the same system for Housing Benefit notifications, the Ombudsman was not confident of their accuracy either. Therefore, the Ombudsman made further recommendations, as follows, and the Council agreed to implement them:

The complaint was upheld, and it was recommended that the Health Board:

- a) To send a written apology to Mr D once again for the continued delay in correcting the linguistic errors in the Council Tax document (within one month).
- b) To offer £100 in compensation for the injustice caused to him and for his efforts in having to raise the matter with me again (within one month).
- c) To create a formal and written process regarding the procedure the Council has told me it will use to produce the annual Notice (within three months).
- d) The Chief Executive to write to me to provide an assurance that the Council’s documents in relation to Council Tax and Housing Benefits will be sent to the Council’s translation partners to be reviewed (and corrected as required). This task should be completed so that they are issued to the software systems for the next financial year (2019/2020) in relation to Council Tax, and for the following year (2020/2021) for Housing Benefit.
- e) In the meantime, to create an accurate individual Council Tax Notice (as they did for Mr D) for any other individual who requests it in Welsh (as required, before releasing the new Notice for the next financial year).

Section 16

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

Powys Teaching Health Board – Continuing Care

Case number 201702418, 201702773 & 201703369 – Report issued July 2018

The complainants, Mr P, Mr H and Mr S, complained about delays in the determination of retrospective claims for NHS funded continuing healthcare. At the time the complaints were made to the Ombudsman, none of the complainants had received a determination of their claim.

The Welsh Assembly Government (as it then was) set up a system whereby retrospective claims submitted to individual health boards between August 2010 and April 2014 (known as “Phase 2 cases”) were mostly transferred to Powys Teaching Health Board (“the Health Board”) to be determined. In June 2014 the Welsh Government issued guidance indicating that such claims should take no longer than two years to process. In 2016 the Health Board introduced a new, two stage, process for the management of the large number of outstanding Phase 2 cases. This involves a preliminary review of the claim, which may result in a full review being carried out of a shorter period than that requested.

Mr P’s claim was made to Cardiff & Vale University Health Board on 17 May 2013 and was transferred to the Health Board in July 2014. On 17 August 2017 Mr P was notified of the outcome of the Stage 1 review of his claim, and that the Stage 2 review would be of part of the period claimed.

Mr H’s claim was made to Aneurin Bevan University Health Board on 13 March 2013 and was transferred to the Health Board in July 2014. On 18 August 2017 Mr P was notified of the outcome of the Stage 1 review, and that the Stage 2 review would consider the whole of the period claimed.

Mr S’s claim was made to a local authority on 13 September 2013 and was transferred to the Health Board in July 2014. On 16 August 2017 Mr S was notified of the outcome of the Stage 1 review, and that the Stage 2 review would consider part of the period claimed. Mr S’s claim has now been disallowed.

The Ombudsman found that the failure to determine the claims within the recommended timeframe, or even within a reasonable time, was maladministration. The complainants suffered the injustice of not knowing whether their claims would succeed and, if they were successful, the delay in receiving reimbursement for the costs incurred. He recommended that the Health Board apologise to the complainants and make a payment of £125 to each in recognition of the considerable delay they had experienced.

The Ombudsman also recommended that the Health Board make a similar payment to each claimant whose claim had not been reviewed as at 7 September 2017 and who had waited in excess of two years from the date of the claim being accepted by the relevant Health Board.

The Health Board agreed to implement the recommendations.

Cardiff and Vale University Health Board & Hywel Dda University Health Board – Clinical Treatment in Hospital Case number 201701479 & 201702267 – Report issued in July 2018

Mr B complained that his son (“C”) waited two and a half years for urgent paediatric surgery. Mr B said this was an unnecessary wait and had a significant impact on C’s quality of life. C was 11 years old and a patient of Hywel Dda University Health Board (“the First Health Board”) but as it did not deliver the service C required he was referred to Cardiff and Vale University Health Board (“the Second Health Board”). The Second Health

Board determined C needed urgent surgery. C received surgery 151 weeks (two years ten months and twenty days) after he was referred for treatment. During that time C suffered frequent infections, which required antibiotic treatment, and needed an open wound on his side dressed three times per week.

The Ombudsman found that this delay was unacceptable; C should have been afforded greater clinical priority by the Second Health Board. The Second Health Board did not regularly review C and did not consider the impact C's condition had on his life. Further to this the Ombudsman found that the First Health Board should have provided Mr B with the details of a person he could contact if C encountered a delay with his treatment and that the Second Health Board did not inform the First Health Board that it could not meet the Welsh Government Target for RTT time in this case, and consequently, alternative options for treatment were not considered.

The Ombudsman said that the impact of the delay in treating the debilitating condition, which could not improve without surgery, could not be underestimated and that C's human rights may have been compromised. Both the Health Boards accepted the findings in the report and acknowledged their role in the failings of this case.

The First Health Board agreed that within one month it would:

- a) Apologise to C for its part in the failings identified in this report and make a redress payment to him of £500 in recognition of the injustice he suffered as a result of its actions.

The First Health Board also agreed that within three months it would:

- b) Ensure that all patients referred for a service outside of the Health Board are provided with a point of contact at the First Health Board with whom they can raise concerns if the provider breaches (or indicates it will breach) the 36-week Welsh Government target.
- c) Ensure that if a patient, for whom it has commissioned care, advises the First Health Board that they have (or have been informed they will) wait beyond the 36-week Welsh Government target, a system is in place to ensure that alternative options are considered, based upon the merits of each case.

The Second Health Board agreed that within one month it would:

- d) Meet Mr B (and C, if he would like) to apologise for the failings identified in this report.

The Second Health Board also agreed that within three months it would:

- e) Undertake a review of the complete pathway of care C received since his initial referral to the Second Health Board, in 2009. Any further failings should be considered, along with those already identified in this investigation, using a process akin to the redress arrangements. This should include consideration of both the physical and psychological impact that the delay had on C.
- f) Create a process for paediatric surgery cases, which have been commissioned by another health board, which will trigger engagement with the commissioning health board, if the case is likely to breach the 36-week Welsh Government target, so that alternative options may be considered. It should also commence a review of the processes in place to alert the referring health boards in its other service areas.
- g) Undertake a retrospective audit of the management of all urgent referrals on the waiting list, made to the consultant referred to in this case, since June 2014, using an Independent Consultant Paediatric Urologist. If it is established that the waiting list has not been appropriately managed, or there are other cases where, due to their circumstances, a patient should have been afforded greater clinical urgency, create an action plan to address the concerns.
- h) Refer this report to the Health Board's Equality Manager and to the Quality, Safety and Experience Committee, to identify how consideration of human rights can be further embedded into waiting list decisions.

Newport City Council – Adult Social Services

Case number 201700724 – Report issued in August 2018

Ms C complained that from September 2013 her relative, Ms D, who has learning difficulties, was not provided with adequate care by Newport City Council (“the Council”) and it left her without support. In particular, it did not assess her capacity to oversee her financial affairs or arrange for an appointee to do so.

The Ombudsman found that a formal capacity assessment was not carried out by the Council for a period of almost four years, despite it identifying on five separate occasions that Ms D was vulnerable and did not understand basic money calculations. The Council left Ms D to handle her own financial affairs and at risk of exploitation. Further to this, the Ombudsman found that when the Council was made aware of Ms D being potentially exploited financially, it did not make a safeguarding referral or investigate the concerns that had been raised seriously enough. However, the Ombudsman found that overall the general support offered to Ms D by the Council was reasonable.

The Ombudsman said that Ms D should have been safeguarded financially by the Council and it was a significant injustice that she was not. The Council accepted the findings in the report and acknowledged its role in the failings of the case.

The Council agreed to take the following actions:

Within one month:

- a) Write appropriate letters of apology for the failings identified in this report.
- b) Make a payment to Ms D of an agreed amount for the identified failing of not adequately assessing her need for financial safeguards between September 2013 and April 2017.
- c) Make a payment of £500 to Ms C in recognition of the distress caused by its failure as outlined in (b) and ignoring her correspondence.

Within three months:

- d) Ensure that arrangements are in place, so consideration is given to financial management during its annual review of cases and determine how it will review concerns it receives in relation to financial issues and capacity.
- e) Discuss the contents of this report with the Community Adult Learning Disability Team to identify learning areas.
- f) Ensure arrangements are in place so relevant staff are reminded of the need to take accurate notes and evidence the rationale for decisions in relation to capacity.

g) Within six months:

- h) Demonstrate that all relevant Social Workers have either recently undergone or will undergo refresher training in relation to the Mental Capacity Act and how to undertake and record capacity assessments.

Cwm Taf University Health Board – Patient list issues

Case number 201703374 – Report issued in September 2018

Mrs A complained that Cwm Taf University Health Board (“the Health Board”) delayed in providing her son, Mr B, with appropriate and timely mental health and autism spectrum disorder (“ASD”) assessments. She also complained about the Health Board’s failure to provide her with a robust response to her complaints.

In 2015, a Crisis Team assessed Mr B’s psychiatric and psychological needs and referred him for both ASD and mental health assessments. My investigation found that the Health Board’s practice of referring patients for ASD assessment prior to a referral for a mental health assessment was contrary to guidance

and good clinical practice. In Mr B's case, his ASD assessment was not completed until May 2017. During this time, the Health Board failed to take any action to either consider, or provide for, Mr B's mental ill health. It was therefore two years before his mental health needs were assessed.

The Health Board's care fell below expected standards, good clinical practice and guidelines in terms of its lengthy delay in completing Mr B's ASD assessment, its failure to consider Mr B's co-existing mental health needs, and its failure to refer Mr B for a mental health assessment at the same time as his ASD referral. It was not possible to determine whether Mr B's situation would have been different had the Health Board's failings not occurred, but it caused him uncertainty and distress. His human rights under Article 8 were engaged as a consequence of the Health Board's identified failings.

When the first Community Mental Health Team ("CMHT") finally assessed Mr B's mental health needs, it concluded that Mr B should be accepted for secondary mental health services. Mr B changed address soon after this assessment and had to be assessed by the second CMHT. This concluded that Mr B was not eligible for secondary mental health services. The investigation was unable to reconcile the differing decisions of the two CMHTs within the same Health Board and only six weeks apart.

The Health Board's complaints response failed to address some of Mrs A's specific concerns.

The Ombudsman upheld Mrs A's complaints and made recommendations which were accepted by the Health Board. These included:

- a) Financial redress payments and appropriate apologies to both Mrs A and Mr B for the failures identified.
- b) A review of current practice to ensure it follows guidelines to allow patients with dual ASD and mental health needs to be assessed concurrently.
- c) An audit of a sample of patients who had been referred for ASD and mental health assessments to ensure others had not been similarly disadvantaged.
- d) An audit of a sample of mental health assessments from both the first and second CMHTs for a consistent application of the criteria for access to secondary mental health services.
- e) A reassessment of Mr B's mental health needs and eligibility for secondary mental health care services.

Health

Upheld

[Betsi Cadwaladr University Health Board – Clinical Treatment in Hospital](#)

[Case number 201703367 – Report issued in July 2018](#)

Mrs M complained about the care and treatment her late brother Mr A received in Ysbyty Glan Clwyd (“the Hospital”) between 1 and 8 March 2017.

The Ombudsman’s investigation concluded that whilst broadly the care provided to Mr A was reasonable and appropriate, he also found similar shortcomings in nursing care to that of Betsi Cadwaladr University Health Board (“the Health Board”). The investigation also found some inadequacies in record keeping and communication which meant that it was not always possible to be clear as to the quality of nursing care delivered to Mr A. The Ombudsman concluded that the shortcomings identified amounted to service failings and maladministration. To this extent only he upheld this part of Mrs M’s complaint.

The Ombudsman made a number of recommendations which included the Health Board apologising to Mrs M and her family for the failings identified as well as the Health Board reminding medical and nursing staff of their professional accountability when it comes to record keeping and communication with patient and family members.

[Betsi Cadwaladr University Health Board & Welsh Ambulance Services NHS Trust](#)

[– Clinical Treatment in Hospital](#)

[Case number 2010702470 & 201703840 – Report issued in July 2018](#)

Miss X complained about the care and treatment provided to her late brother, Mr Y, by the Welsh Ambulance Services NHS Trust (WAST) and Betsi Cadwaladr University Health Board (“the Health Board”). She complained about a delay in the ambulance crew attending Mr Y, the time taken to transport him to hospital and whether his prioritisation was appropriate. She complained that when he arrived at hospital, there was a delay in transferring Mr Y to the Emergency Department (“ED”) and that his observations were not carried out frequently enough which led to a delay in identifying a brain haemorrhage. Miss X was concerned his condition was not taken seriously due to an assumption of alcohol consumption. Miss X was also concerned that Mr Y did not received appropriate nursing care.

The investigation found that the prioritisation of the call was appropriate. It also found that that whilst there was a delay in an ambulance arriving at the scene, WAST had made every effort to attend Mr Y as soon as reasonably practicable within the resources it had. However, the delay in transporting Mr Y to hospital once paramedics had arrived was outside the bounds of acceptable clinical practice. This element of the complaint was upheld.

The investigation also found there was a delay in transferring Mr Y’s care to ED. However, the hospital was under extreme operational pressure which was being managed, Mr Y was regularly monitored and, as soon as his condition deteriorated, he was transferred to ED.

There was no evidence to substantiate Miss X’s concern about alcohol consumption. Shortcomings in record keeping relating to nursing care indicated that nursing care was not of the standard expected. This element of the complaint was upheld.

Aneurin Bevan University Health Board – Clinical Treatment in Hospital

Case number 201703179 – Report issued in July 2018

Mr S complained about the care and treatment that his late mother, Mrs M, received at the Royal Gwent Hospital's Maxillofacial & Oral Surgery Unit ('the Unit') where she underwent surgery to excise a cancerous growth from her nose. Mr S complained that:

1. Mrs M was told that the surgery would be carried out under general anaesthetic (GA) and that she should remain nil by mouth on the day of the operation. However, on arriving at the Royal Gwent Hospital, Mrs M was shocked and upset to discover that the procedure would be carried out under local anaesthetic (LA)
2. Mrs M was inadequately anaesthetised and found the procedure extremely unpleasant. She subsequently experienced avoidable post-operative distress, pain and discomfort
3. A consent form was not completed prior to the procedure and Mrs M was not, therefore, properly informed of the risk of post-operative pain and other complications that she subsequently experienced.

The Ombudsman, assisted by his clinical adviser, found that although the LA that Mrs M received was anaesthetically adequate, in view of the extensive nature of the surgery, she should have been offered the option of a GA. As there was no evidence of any compelling medical reasons for not offering her a GA, the Ombudsman upheld complaint number two.

Whilst the Ombudsman's investigation could not determine how Mrs M came to believe that she would receive a GA rather than a LA, and whilst appropriate consent forms were completed, he nevertheless partially upheld complaints one and three on the basis that the decisions and discussions about these matters were not adequately recorded in Mrs M's medical records (in accordance with relevant guidance). The Ombudsman considered that this failing resulted in an injustice to Mrs M (and to Mr S), as these elements of the complaint could not be fully evaluated.

The Ombudsman recommended that Aneurin Bevan University Health Board ("the Health Board") provides Mr S with a fulsome apology for the identified failings and, in recognition of the distress and uncertainty that they gave rise to, makes a payment to him of £500.

The Ombudsman also recommended that:

1. Physicians at the Unit are reminded of contemporary developments in guidance governing how consent is obtained and recorded, and of their obligation to keep clear, accurate records of discussions and decisions
2. The Health Board conducts an audit of facial surgery procedures conducted at the Unit since 2015. The audit should examine and report on the relative frequency of the use of local and general anaesthetic to ensure that decisions about anaesthesia are based on the clinical circumstances of each case and reflect established practice in this domain.

The Health Board has agreed to implement these recommendations.

Cwm Taf University Health Board – Clinical Treatment in Hospital

Case number 201700805 – Report issued in July 2018

Mrs A complained about the care and treatment her late mother, Mrs X received from Cwm Taf University Health Board ("the Health Board"). Specifically, Mrs A complained that the identification of a mass on Mrs X's liver should have prompted further investigations and, that Mrs X should have been given a follow up

appointment following gallbladder surgery. Mrs X also complained that there was a failure to appropriately administer Mrs X's medication and meet her needs following her stroke. Mrs A also said that Mrs X's discharge from hospital was unsafe. Mrs A said that, in her view the Health Board prioritised the care of Mrs X's cancer rather than the stroke and that the cancellation of a diagnostic procedure caused a delay in retrieving a biopsy of Mrs X's tumour. Finally, Mrs A complained that there was poor communication and that the Health Board failed to adequately respond to her complaints.

The investigation found that there had been a failure to document when and why medication had not been administered to Mrs X. The investigation also found that Mrs X had been discharged from hospital following significant diagnosis without any discharge assessment or referral to community support services. The investigation found that, following her stroke, the Health Board failed to meet Mrs X's needs and maintain her dignity. Finally, the investigation found that the Health Board had failed to appropriately respond to Mrs A's complaint in accordance with the Putting Things Right complaints process.

It was recommended that the Health Board apologises to Mrs A and pays her £500 in recognition of the poor complaint handling and distress in having to bring her complaint to this office. It was also recommended that the Health Board reminds complaint handlers to review complaint responses and ensure that technical terms are fully explained. It was recommended that the Health Board reminds nursing staff that, when medication has not been administered, an explanation should be noted in the medication chart and, the Occupational Therapy Team of their record keeping responsibilities. Finally, it was recommended that the Health Board reminds all staff of their responsibilities when safely discharging a patient.

[Betsi Cadwaladr University Health Board – Clinical Treatment in Hospital](#) [Case number 201702513 – Report issued in July 2018](#)

Mr A complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to diagnose his condition correctly when he attended one of its Emergency Departments with sudden and severe abdominal pain. He also complained that the Health Board took too long to respond to his complaint about that issue.

The Ombudsman determined that the Health Board had misdiagnosed Mr A's condition. He indicated that it should have made a provisional diagnosis of biliary colic¹ and not constipation. He upheld the clinical care element of Mr A's complaint. The Ombudsman found that the Health Board's response to Mr A's complaint had been unreasonably delayed and that the involvement of a particular staff member, in its investigation of that complaint, had been inappropriate. He upheld the complaint handling part of Mr A's complaint. He recommended that the Health Board should apologise to Mr A for the clinical care and complaint handling failings identified. He asked the Health Board to pay Mr A £500 in recognition of the adverse impact that the clinical care failings specified had probably had on Mr A and his wife, Mrs A. He also recommended that the Health Board should explain to Mr A why its written response to his complaint had been delayed. The Health Board agreed to implement these recommendations.

[Abertawe Bro Morgannwg University Health Board – Clinical Treatment in Hospital](#) [Case number 201701827 – Report issued in July 2018](#)

Mrs Y complained that following the admission of her late husband ("Mr Y") to A&E at the Princess of Wales Hospital, his pain was not managed appropriately and there had been a delay in his treatment. She was also concerned that he did not have an operation to address an infection in his elbow quickly enough. Sadly, Mr Y died of an infection after his operation.

The Ombudsman found there had been a delay in administering Mr Y with antibiotics in accordance with the Health Board's sepsis¹ toolkit. However, there was no uncertainty that this delay would have affected the progression of his infection. The Ombudsman considered however that this uncertainty amounted to an injustice to Mr Y's family and accordingly upheld the complaint. The Ombudsman did not however find sufficient evidence to conclude that Mr Y's pain management had been inadequate. He also considered that Mr Y's operation was undertaken in a timely manner.

The Ombudsman recommended that Abertawe Bro Morgannwg Health Board apologise to Mr Y's family and conduct an audit of patients admitted to the hospital to ensure that the administration of antibiotics occurs in accordance with the timescales in its sepsis toolkit.

[Betsi Cadwaladr University Health Board – Clinical Treatment in Hospital](#)

[Case number 201702784 – Report issued in July 2018](#)

Mrs B complained to the Ombudsman that her late husband, Mr B, who was very unwell had been inappropriately moved from the cardiac ward of Ysbyty Gwynedd into a store room on the ward. This happened on two separate occasions during the early hours of the morning. Mrs B was also concerned that the room was ill-equipped to look after patients safely and questioned why Mr B had been selected to be moved into the store room when on the face of it, less ill patients were not moved.

The Ombudsman found that it is commonplace for hospitals to have to use non-clinical spaces as escalation areas when capacity to accept patients is exceeded. This was the case on the two occasions Mr B was moved into the store room. The Ombudsman recognised Betsi Cadwaladr University Health Board ("the Health Board") staff do not wish to take such action, but it is necessary to ensure overall patient safety. He did not uphold this element of the complaint. However, in Mr B's case the store room had not been used previously to nurse patients and staff were not expecting or prepared to use it in this way.

The Ombudsman found that as a result, it was inappropriate to have used this room to care for Mr B given its inadequate provision and facilities. He upheld this element of the complaint and recommended the Health Board review all escalation areas to ensure that they are suitable and sufficiently equipped to provide appropriate patient care.

Finally, the Ombudsman found that it would have been clinically acceptable to have transferred Mr B to the store room (had it been appropriately equipped) but was unable to comment on whether it would have been more appropriate to move other patients instead of Mr B as it dependent on their individual clinical situation.

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

[Case number 201703578 – Report issued in August 2018](#)

Ms N complained that Aneurin Bevan University Health Board ("the Health Board") removed her daughter, K, from dialectical behaviour therapy (DBT) without considering the effect this decision would have on her and without a suitable treatment plan in place. Ms N was also unhappy that the Health Board failed to communicate with K leading up to and following her removal from DBT.

The Ombudsman's investigation found that the Health Board undertook a carefully considered decision to remove K from DBT, that it was made in her best interests and there were suitable support packages available following her removal. The Ombudsman did, however, conclude that communication between

the Health Board and Ms N and K was strained at times due to the multitude of professionals involved in K's care. This resulted in confusion, mixed messages and the Health Board giving K a handout with inappropriate advice.

The Ombudsman recommended that the Health Board apologise to both Ms N and K for the failings identified. He also recommended that the Health Board reviews how it communicates with young patients, that it considers a single point of contact in complex cases when multiple professionals are involved, and it reviews its DBT handouts to ensure they are appropriate for young people with complex disorders.

[Betsi Cadwaladr University Health Board – Health](#) [Case number 201705880 – Report issued in August 2018](#)

Mr C complained about the overall care and treatment he received in Ysbyty Glan Clwyd ("the Hospital") between 11 and 27 September, including whether he was discharged appropriately.

The Ombudsman's investigation determined that following Mr C's admission after suffering a seizure at his holiday home, and a further seizure whilst in the ambulance, Mr C suffered a third seizure whilst in the Emergency Department. This was contrary to what Betsi Cadwaladr University Health Board ("the Health Board") had told Mr C. Following two X-rays, Mr C was found to have dislocated and fractured both his shoulders. The Ombudsman, however, could not be certain when these injuries occurred because of inadequate record keeping. After successful surgery on both shoulders, the Hospital discharged Mr C but the Ombudsman found that the discharge planning was inadequate. Poor communication between staff regarding whether Mr C would stay locally or return to England, led to delays in follow-up treatment and Mr C having to find a local GP himself.

The Ombudsman upheld Mr C's complaint and recommended financial redress in recognition of the delay in identifying his injuries and the poor discharge planning. The Ombudsman also recommended that the Health Board considered how it could improve its communication and discharge process for 'holiday' patients when they required further acute care.

[Cardiff and Vale University Health Board – Health](#) [Case number 201704527 – Report issued in August 2018](#)

Ms C complained that she suffered complications as a result of an operation to remove her gall bladder. In particular, Ms C was concerned that she was not kept in overnight when she suffered a capsular tear to her liver during the procedure. She was also concerned about the standard of communication with her and her family and that when she was readmitted to hospital, there was a delay in diagnosing and treating sepsis. Ms C was also concerned about her pain management during these admissions.

The Ombudsman found that the operation was carried out to an appropriate standard and Ms C suffered a recognised complication of the procedure. It was appropriate in the circumstances for her to have been discharged home. The Ombudsman found that when Ms C was readmitted, her sepsis was recognised and addressed within a reasonable timescale. However, the Ombudsman was critical of delays in carrying out a CT scan and in reviewing the scan once it was available. This caused a small delay in Ms C's subsequent operation. To that extent only, he upheld the complaint. The Ombudsman did not uphold the complaints about pain management and communication. The Ombudsman recommended that Cardiff and Vale University Health Board apologise to Ms C, that it should review its procedure for authorising CT scans, and review its practice in deciding which is the appropriate surgical team to refer a patient to in the circumstances in which Ms C was admitted.

Aneurin Bevan University Health Board – Health Case number 20170503 – Report issued in August 2018

Mr A complained about the care and treatment provided to his late partner Ms D during her inpatient stay at the Royal Gwent Hospital (“the Hospital”) between March and April 2017. He also complained about the Aneurin Bevan University Health Board’s (“the Health Board”) handling of his complaint.

The Ombudsman’s investigation found that there were shortcomings in the nursing care provided to Ms D, who was vulnerable and at high risk of choking due to her condition. He considered the failure caused Ms D discomfort at a time when her condition was slowly deteriorating and caused additional and unnecessary distress to Ms D and her partner.

The Ombudsman was of the view that had a personalised nursing care plan been in place from the outset it would have prevented Ms D being fed porridge and being given mouth wash for oral hygiene. The investigation also identified shortcomings, some of which the Health Board had identified, in the completion of nursing assessments such as food and fluid charts as well as poor communication.

The investigation also found that Mr A was caused distressed by seeing his partner left in an undignified way shortly after her death. The Ombudsman made it clear that dignity is as important after death as in life and that where this is not taken care it can have a significant impact on the family member left behind and how they cope with their loved one’s death. Mr A’s complaint was upheld. The Ombudsman’s recommendations included the Health Board apologising to Mr A for the shortcomings identified and paying Mr A £500 for the distress caused by the clinical failings which were compounded by failings around dignity and £250 for inadequacies in complaint handling.

Aneurin Bevan University Health Board – Health Case number 201701687 – Report issued in August 2018

Mr P complained to the Ombudsman about the care and treatment he received following his referral to Aneurin Bevan University Health Board’s (“the Health Board”) Trauma & Orthopaedic Directorate with pain and loss of function in his right shoulder. Mr P complained that:

- a) Clinicians declined to conduct an ultrasound (“US”) scan of his shoulder as requested by his GP. Whilst this decision reflected changes to the Health Board’s US guidelines, it delayed / prevented a definitive diagnosis being reached.
- b) For over a year, he attended physiotherapy outpatient appointments but, despite repeated requests, he was never seen by a consultant or referred to a shoulder surgeon.
- c) After a year of increasing pain and frustration, he sought a private orthopaedic opinion. A private surgeon quickly diagnosed and surgically repaired a rotator cuff tear¹. Mr P complained that, for over a year, NHS clinicians failed to identify this common shoulder condition.

The Ombudsman, through his Clinical Adviser, upheld Mr P’s complaints. He recommended that the Health Board provides a fulsome written apology to Mr P which recognises the clinical and communication failings identified in the report and which also address the Health Board’s significant delay in confirming that it accepted the report’s findings and recommendations.

The Ombudsman also recommended that the Health Board, in recognition of these failings, makes a payment to Mr P in the sum of £1,000.

The Ombudsman further recommended that senior physicians at the Health Board's Trauma & Orthopaedic Directorate are reminded of the need to ensure that patients who fail to respond to conservative treatment receive a consultant-led, clinical assessment and appropriate investigative scans in a timely manner.

Finally, the Ombudsman recommended that the Health Board reviews its revised US guidelines and considers:

- a) Clarifying and specifying the criteria for accepting shoulder-scan referrals in greater detail (so that GPs know where and when to refer patients)
- b) Co-ordinating and integrating the use of US scans into the treatment pathway for patients with suspected impingement and rotator cuff tears.

I am pleased to note that the Health Board has agreed to implement these recommendations.

[Betsi Cadwaladr University Health Board – Health Case number 201702075 – Report issued in August 2018](#)

Ms T complained that, having been referred to the Urology Service at Ysbyty Gwynedd by a private Consultant Urologist for an investigative cystoscopy procedure (the findings of which were normal), she was discharged with no plan for further investigation of her symptoms of persistent urinary tract infections (UTIs) and overflow urinary incontinence.

Ms T described how:

- She felt 'abandoned' by NHS clinicians, who failed to take account of her history of spinal nerve compression and failed to note that a scan, conducted some days before the cystoscopy, revealed that her cauda equina (a nerve junction in the spine) appeared "compromised"
- She subsequently felt obliged to obtain a referral to a second private Consultant Urologist who promptly arranged for her to undergo urodynamic assessments.

The Ombudsman upheld Ms T's complaint and recommended that Betsi Cadwaladr University Health Board ("the Health Board") provide her with a fulsome apology for the failings identified, together with a payment of £500 in recognition of the expense and inconvenience that she encountered in pursuing alternative sources of treatment and in pursuing her complaint about this matter.

The Ombudsman also recommended that the Health Board reminds Urology Service physicians that referral of patients to the NHS from private consultations does not relieve them of the duty of care owed to patients referred to the NHS from any other source. The Health Board accepted these recommendations.

[Betsi Cadwaladr University Health Board – Health Case number 201702873 – Report issued in August 2018](#)

Mr X complained that there had been a delay in undertaking a template biopsy of his prostate following a referral from the Consultant Urologist and, that there had been poor communication on the part of Betsi Cadwaladr University Health Board ("the Health Board").

The investigation found that, whilst the decisions relating to the type of treatment Mr X received were reasonable, the delays in providing that treatment were unreasonable and not in accordance with the Welsh Government's Referral Guidelines for Suspected Cancer. The investigation also found that, throughout the process, there had been little communication or support provided to Mr X by the Health Board.

The complaint was upheld, and it was recommended that the Health Board apologise to Mr X and pay him £3750 in recognition of the delays, poor communication and lack of support experienced during this difficult time. It was also recommended that the Health Board provide a further update on its capacity to provide or to commission template biopsies within 31 days of referral and review its process for the provision of support to patients who have been informed that they may have cancer. Finally, it was recommended that the Health Board discuss the findings of this report with the relevant clinicians and officers.

[GP Practice in the area of Aneurin Bevan University Health Board – Health Case number 201702516 – Report issued in August 2018](#)

Mr Y complained that Mrs X had been issued with prescriptions over the telephone without being examined by a GP at a GP Practice (“the GP Practice”) in the area of Aneurin Bevan University Health Board. Mr Y also raised concerns over whether tests and investigations carried out into Mrs X’s condition were reasonable and appropriate, and if opportunities had been missed to diagnose Mrs X with bowel cancer. Mr Y also complained that, during a telephone call to the GP Practice he was told by the receptionist to call the Out of Hours (“OOH”) GP service once the GP Practice had closed.

The Ombudsman found there was an occasion when Mrs X was prescribed medication without being seen and deemed this was inappropriate. There was no evidence however that this was a regular practice and the complaint was partially upheld. The Ombudsman was unable to conclude with any confidence whether the provision of tests and investigations were reasonable due to the inadequate record keeping by GP’s. This element of the complaint was upheld.

The Ombudsman found that it was unacceptable that the task of telephoning a patient fell to a receptionist. The advice given to contact an OOH GP would have been acceptable had a GP undertaken a telephone assessment and recorded the rationale for the decision not to visit Mrs X; however, this was not the case and the complaint was upheld. The Ombudsman recommended that the GP Practice apologise to Mr Y for the failings identified, remind relevant staff of the importance of full and accurate record keeping and review its practices to ensure that correspondence concerning patients was immediately available electronically for GPs to access.

[GP Practice in the area of Betsi Cadwaladr University Health Board – Health Case number 201703689 – Report issued in August 2018](#)

Ms A complained about the way a GP Practice (“the GP Practice”) in the area of Betsi Cadwaladr University Health Board, administered a contraceptive injection and that it did not appropriately inform her about its side effects. Ms A said the contraceptive injection caused an abscess which required surgery under general anaesthetic.

The Ombudsman found that the way the GP Practice administered Ms A’s contraceptive injection was not in line with good practice and guidance and could have increased Ms A’s risk of an adverse reaction. He also found documentation relating to the administration of the injection did not appear to be in line with required standards. The Ombudsman upheld this element of the complaint.

The Ombudsman found that the approach adopted by the GP Practice in respect of advising Ms A about side effects was appropriate. He did not uphold this element of the complaint.

The Ombudsman recommended that the GP Practice write to Ms A to apologise for the failings identified and provide a redress payment of £250 to reflect the distress and inconvenience she experienced. He also recommended that the findings were shared with relevant staff at the GP Practice, and that it reported the incident to the Medicines and Healthcare products Regulatory Agency.

[Aneurin Bevan University Health Board – Health Case number 201705098 – Report issued in August 2018](#)

Mrs B complained about the care and treatment her daughter (“C”) received from the Aneurin Bevan University Health Board (“the Health Board”). She complained that the Health Board failed to diagnose C’s condition during Mrs B’s pregnancy, failed to recognise that C’s medical history and ongoing symptoms were due to the undiagnosed condition (resulting in C not being diagnosed until she was four) and then took too long to arrange an appointment with a specialist following the diagnosis. Mrs B also said the Health Board failed to arrange a meeting to discuss unresolved concerns and the request was poorly handled.

The Ombudsman found that that the overall care C received was good. There were some delays in the pathway but, generally, the care was timely and appropriate and there is nothing to indicate that more regular reviews by the Paediatric Orthopaedic Service would have changed C’s care or treatment. Whilst the referral to the specialist took an extended period, appropriate referrals were made for treatment whilst the family awaited that appointment and the delay did not impact on the treatment given to C.

The Ombudsman also found that despite chasing the Health Board on numerous occasions, a meeting requested by Mrs B never happened. The Health Board eventually stopped responding to Mrs B’s advocate’s requests to be updated and this was unacceptable. The Health Board agreed to apologise to Mrs B and make a payment of £100 in recognition of the inconvenience caused.

[Cardiff and Vale University Health Board – Clinical treatment in hospital Case number 201700182 – Report issued in September 2018](#)

Mrs J complained about the care and treatment she received from a Consultant Orthopaedic Surgeon between 5 January and 22 June 2016. Mrs J underwent four surgical interventions during this time to address pain in her left hip. In particular, Mrs J complained about the Consultant Orthopaedic Surgeon’s failure to take into account her pre-existing conditions and explain the risks and possible outcomes of a hip operation that left her with one leg significantly shorter than the other and having to wear an external shoe raise.

The Ombudsman’s investigation found that the Consultant Orthopaedic Surgeon failed to appropriately inform Mrs J of all the risks of her complex surgery or outline what non-surgical options might be available. He also failed to record adequate notes, which brought into question whether Mrs J had given informed consent. The Ombudsman also found that whilst Mrs J suffered a fracture following her first surgery that impacted her significantly, the Consultant Orthopaedic Surgeon carried out the operation competently.

The Ombudsman upheld Mrs J’s complaint and recommended an apology and significant financial redress. The Ombudsman also recommended that the Consultant Orthopaedic Surgeon undergoes refresher training on obtaining consent and creates a patient information document that details the risks and possible outcomes for patients of hip revision surgery.

Hywel Dda University Health Board – Clinical treatment in hospital

Case number 201704879 – Report issued in September 2018

Mrs X attended Prince Philip Hospital on 5 April 2016 for a total hip replacement. Following this procedure, she was unresponsive, and her drowsiness was assumed to be because of post-operative recovery. She was unsuccessfully administered antidotes for anaesthesia. Mrs X was later found to have suffered a major stroke. Mrs Y complained about the treatment her late sister, Mrs X received between 5 and 8 April 2016, that her hole in the heart had only been detected on 8 April and Mrs X had not been in a private setting when she died on 14 April.

The Ombudsman found that on 5 April, Mrs X should have had a full neurological examination, the antidotes administered considered and a CT head scan arranged. A CT scan conducted the next day led to a failure in informing Mrs X's family the severity of her situation. He had no criticism that Mrs X's hole in the heart was not detected until 8 April, as it did not need investigation before the procedure. The Ombudsman found that on 14 April, there was no suitable room available for Mrs X's end of life and while not the best option, in the circumstances it was appropriate. Hywel Dda University Health Board agreed to implement the Ombudsman's decision and apologise to Mrs X's family for the failings, make a redress payment of £750, remind staff that an appropriate assessment tool be used for drowsy patients and reviews whether a handover tool should be used when moving a patient from the recovery ward to the wards and from the wards to ITU.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case number 201800346 – Report issued in September 2018

Mr F complained that, between 5 August 2016 and 9 June 2017, Betsi Cadwaladr University Health Board ("the Health Board") failed to appropriately diagnose and treat the cause of his Eustachian tube (which connects the back of the nose to the middle ear and regulates pressure in the ear) dysfunction, misinformed him about his condition and treatment options, and inappropriately referred him to another hospital for treatment which it did not offer.

The Ombudsman found that the Health Board appropriately and promptly diagnosed Mr F's Eustachian tube dysfunction and offered treatments in line with accepted reasonable clinical care, although Mr F should subsequently have been referred for an MRI scan to ensure there was no alternative cause of his symptoms. Furthermore, when Mr F was referred to another hospital for treatment the Health Board should have clearly explained what was available, and that there was no guarantee the referral would result in any further treatment.

The Health Board agreed to apologise to Mr F for failing to manage his expectations appropriately, and for the misleading and futile referral. It also agreed to reflect on the Ombudsman's findings, particularly its duty to provide honest and realistic opinions and manage patient's expectations appropriately, and to consider why the MRI scan was overlooked. Finally, it agreed to ensure there is a process in place by which all Consultants maintain up to date awareness of what treatments are offered by their colleagues throughout the Health Board, and the wider medical community.

Hywel Dda University Health Board – Clinical treatment in hospital

Case number 201704013 – Report issued in September 2018

Mr A complained about the care and treatment he received from the Accident and Emergency department ("ED") at Glangwili Hospital on 17 February 2017 and Wthybush Hospital on 22 March. Mr A also complained about poor communication and complaint handling.

The Ombudsman's investigation found that broadly the clinical care provided to Mr A at both Hospitals' ED departments was reasonable and this also applied to the follow up care at Glangwili Hospital. The Ombudsman concluded that given the extent of Mr A's injury there was deficiency around pain management. He also found that there were shortcomings around communication and complaint handling. Mr A's complaint was upheld to that extent.

Amongst the recommendations the Ombudsman made were that Hywel Dda University Health Board ("the Health Board") should apologise to Mr A for the failings identified and pay him a sum of £250 for the distress and frustration the failings in communication and complaint handling had caused. In addition, the Health Board was to make a further payment of £125 for poor pain management following Mr A's initial discharge. The Ombudsman also made recommendations around clinical care.

[GP practice in the area of Cwm Taf University Health Board and Cwm Taf University Health Board – Clinical treatment in hospital](#)

[Case number 201704158 & 201705303 – Report issued in September 2018](#)

Mrs T complained about:

a) the GP Practice's failure to:

- Recognise the seriousness of her mother, Mrs J's, illness and arrange appropriate investigations
- Ensure Mrs J received adequate pain relief in the last weeks of her life.

b) the failure of Cwm Taf University Health Board's ("the Health Board") district nursing service to:

- Control Mrs J's pain in the last weeks of her life
- Appreciate Mrs J was nearing the end of her life (when she died an hour after their last visit).

The Ombudsman found that the GP Practice had, initially, responded appropriately as Mrs J's symptoms gave doctors no reason to believe that further investigations were necessary. However, it was likely that Mrs J's diagnosis would have been made a month sooner if her pain had been explored earlier, although this would not have affected the outcome. Mrs J's pain had been managed appropriately after her diagnosis. The Ombudsman partly upheld the complaint against the GP Practice.

The Ombudsman found that the district nursing service had managed Mrs J's pain appropriately, although it should have been more proactive to ensure additional pain relief was available at a weekend, if needed. He could not determine what had been said during the nurse's final visit as accounts differed. He partly upheld the complaint against the Health Board.

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

[Case number 201703648 – Report issued in September 2018](#)

Mr G complained that, as a result of a medication dispensing error by clinicians at Glangwili Hospital's Special Care Baby Unit (SCBU), his granddaughter, Baby K (then two days old), was given an excessive dose of the antibiotic Gentamicin. Mr G complained that, despite Hywel Dda University Health Board's ("the Health Board") assurance that Baby K was not harmed by this error, it placed her at risk of developing hearing loss. Mr G also complained that:

a) There was a considerable delay before clinicians informed Mr G's daughter, Ms B (Baby K's mother), about this error. The manner in which this was done was upsetting for Ms B and was made worse by a junior doctor incorrectly suggesting that the excessive dose of Gentamicin could result in Baby K suffering liver damage.

b) There was a protracted delay in the Health Board providing its formal, written response to the family's complaint about this matter. Mr G considered that the response was defensive and that it failed to recognise the impact the incident had on the family.

The Ombudsman, through his clinical advisers, upheld Mr G's complaints. He determined that the error came about as a result of a junior doctor mis-entering the dates on a prescription chart which nurses subsequently failed to scrutinise. Although Baby K was given the correct dose of Gentamicin, it was given 24 hours before it was due.

Whilst there was no evidence that Baby K was harmed as a result of this error, it was a traumatising experience for Ms B and her family as they had to wait for Baby K to undergo screening by a Paediatric Audiologist before they could be confident that Baby K's hearing had not been damaged.

The Ombudsman also found that clinicians were slow to inform Ms B about the error and that the manner in which this was done was upsetting for her (as she was alone at the time). This failing was compounded by a junior doctor incorrectly suggesting that the excessive dose of Gentamicin could result in Baby K suffering liver damage.

Finally, the Ombudsman agreed that there were failings in the Health Board's handling of the family's complaint.

The Ombudsman recommended that Ms B receive a fulsome apology and £500 in recognition of the distress caused to her by the identified failings of care and complaint-handling. He also recommended that the Health Board share the report with all relevant clinicians on the SCBU and provides the Ombudsman with evidence of the re-training that the nurses and junior doctors received following the incident. The Ombudsman recommended that the Health Board considers developing a Patient Information Leaflet that answers frequently asked questions about the septic screening of neonates and the use of blood tests, antibiotics and common treatment regimens; and develops an exemplar prescription chart for the use of Gentamicin on the SCBU to help junior doctors see clearly what is expected and to clarify the standards required by the Health Board.

Finally, the Ombudsman recommended that the Health Board shares the report with the Concerns Team and draws to its attention the complaint handling failings identified.

The Health Board accepted the Ombudsman's recommendations.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#) [Case number 201607513 – Report issued in September 2018](#)

Ms B complained about the clinical care given to her late brother, Mr B, by Betsi Cadwaladr University Health Board ("the Health Board") and the Health Board's related communication. She made this complaint in her own right and on behalf of her other brothers, Mr C and Mr D. The clinical care aspect of her complaint concerned fluid, nutrition and medication withdrawal, mobilisation and the diagnosis and treatment of pneumonia. Its communication element pertained to decisions about the completion of a 'Do Not Attempt Cardio-Pulmonary (sic) Resuscitation ("DNAR") Form' and treatment withdrawal. Ms B also said that the Health Board took too long to respond to her complaint.

The Ombudsman could not determine that the withdrawal of Mr B's fluid, nutrition and medication had been clinically inappropriate. He found that Mr B's mobilisation had been clinically reasonable. He did

not consider that the apparent delay associated with the diagnosis and treatment of Mr B's pneumonia was clinically significant. He did not uphold the clinical care aspect of Ms B's complaint. The Ombudsman determined that the Health Board's management of the DNAR decision-making process was deficient. He partly upheld the communication element of Ms B's complaint. The Ombudsman found that the Health Board's response to Ms B's complaint was unreasonably delayed and that it had not addressed Mr C's concern about that response. He upheld the complaint handling part of Ms B's complaint. He recommended that the Health Board should apologise to Ms B for the failings identified. He asked it to send Mr C a full response to his concern. He also recommended that it should formally remind clinicians of the consultation requirement that relates to DNAR decisions. The Health Board agreed to implement these recommendations.

[Cwm Taf University Health Board – Appointments/ admissions/ discharge and transfer procedures](#)
[Case number 201703636 – Report issued in September 2018](#)

Mr D complained to the Ombudsman about the treatment his late mother, Mrs D, received from Cwm Taf University Health Board ("the Health Board") following her admission to the Royal Glamorgan Hospital in April 2017. In particular, Mr D was concerned about the arrangements that Hospital staff had put in place to ensure that Mrs D was discharged appropriately. He was also concerned, that during her admission and upon her discharge home, Mrs D was not given appropriate antibiotic treatment. A few days following her discharge home, Mrs D's GP prescribed antibiotic treatment for an infection.

The Ombudsman found no evidence that Mrs D's discharge was planned. Mrs D was clearly at risk of falling and needed the use of a zimmer frame to move around. Whilst it is accepted that Mrs D was medically fit for discharge, the Ombudsman was of the view that she should have received an assessment before discharge. The manner in which Mrs D was discharged was not in keeping with the Health Board's discharge procedure. Whilst the Ombudsman could not determine with certainty that if an appropriate assessment had taken place, Mrs D would not have been discharged in any case. However, the Ombudsman is of the view that if an assessment had taken place, Mrs D's discharge could have happened in a safer manner and this may have served to alleviate Mr D and his sister's concerns at the time. The Ombudsman upheld this aspect of the complaint.

The Ombudsman also found that, whilst Mrs D had been reported as having a urinary tract infection, as she did not exhibit any adverse symptoms it was reasonable not to have treated her with antibiotics during her admission. He did not uphold this element of the complaint.

The Ombudsman recommended the Health Board apologise to Mr D and his sister for the shortcomings identified. He also recommended that the Health Board should evaluate and take action in relation to any findings stemming from a documentation audit it was undertaking to ensure that there was appropriate risk assessment, discharge planning and communication with patients and relatives.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)
[Case number 201704913 – Report issued in September 2018](#)

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to appropriately investigate and manage her late husband's blood condition, she said it failed to communicate the diagnosis, prognosis and the associated risks.

The investigation found that Mr X was suffering from neutropenia when he was admitted to the Emergency Department ("ED"), advice should have been sought from Haematology prior to discharge and the

timeframe advised for a referral post discharge was not reasonable. The Locum Consultant Haematologist ("the Consultant") did not arrange a biopsy in a timeframe that was appropriate to Mr X's condition. The Consultant believed that Mr X was suffering from Myelodysplasia Syndrome however the condition and poor prognosis were not communicated to him. The Consultant did not inform Mr X that he was susceptible to Sepsis nor did he advised ways in which he could attempt to guard himself. Mr and Mrs X were denied the opportunity of preparing for the likely outcome of his illness, obtaining symptom control and/or palliative care. When Mr X attended the ED, there was a delay in assessment and administration of treatment however the investigation found that the service failure would not have altered the sad outcome.

The Health Board agreed to apologise to Mrs X for the shortcomings identified, make a redress payment of £1,000 in recognition of the injustice she and Mr X suffered and refer the Consultant to the General Medical Council. In addition, it was agreed that training would be provided to all relevant staff in the ED regarding the urgent approach that needs to be taken when profound neutropenia is identified.

[Cardiff and Vale University Health Board – Clinical treatment in hospital](#)
[Case number 201706550 – Report issued in September 2018](#)

Mr X complained about the care and treatment his wife, Mrs X received from Cardiff and Vale University Health Board's ("the Health Board") Out of Hours GP Service ("OOHGP Service"). Mr X complained that appropriate medical checks were not undertaken by the Nurse Practitioner and Mrs X was misdiagnosed.

The investigation found that there were omissions in relation to the investigation and history taking at the consultation. Consequently, a cardiac cause for Mrs X's chest pain could not be ruled out. Mrs X should have been referred to an urgent care setting to ensure further investigations were undertaken to confirm a cardiac cause for her symptoms. If Mrs X had undergone the necessary investigations, it was likely her cardiac difficulties would have been diagnosed at an earlier juncture and treatment would have been administered sooner. If this had happened, the damage caused to Mrs X's heart would have been significantly reduced, it is likely that Mrs X would not have developed a potentially fatal irregular heart beat and insertion of an Implantable Cardioverter – Defibrillator would not have been necessary. Mrs X's rehabilitation would have been simpler, and Mrs X would have had a shorter hospital stay.

The Health Board agreed to apologise to Mr X for the failings identified and pay a redress payment of £3,000 in recognition of the injustice suffered. It was agreed that the Nurse Practitioner would use the complaint as a source of personal reflection during her revalidation with the Nursing and Midwifery Council. The Health Board also agreed to implement and establish a Chest Pain Protocol aimed at reducing the incidences of missed cardiac events within the OOHGP setting and to ensure that onward referrals are appropriate and timely.

[Aneurin Bevan University Health Board – Clinical treatment in hospital](#)
[Case number 201700124 – Report issued in September 2018](#)

Miss D complained about the care and treatment her late partner, Mr P, received at the Royal Gwent Hospital in 2016 prior to his sad death. Miss D complained that Aneurin Bevan University Health Board ("the Health Board") failed to treat Mr P's gallbladder infection appropriately and that communication with her throughout his admission was unsatisfactory. Miss D also complained that Mr P was not adequately monitored during the bank holiday weekend prior to his death, that he should have been moved to a private room when he was seriously ill and that the medical notes kept throughout his admission were unclear.

The Ombudsman found that Mr P received reasonable treatment and that there were no concerns with the medical records kept. These complaints were not upheld. The Ombudsman upheld Miss P's complaint that communication with her was poor and partially upheld her complaints that Mr P was not adequately monitored during the bank holiday weekend and that Mr P should have been considered for a private room when he was seriously ill.

The Ombudsman recommended that the Health Board apologises to Miss P and provides financial redress in the sum of £600 for the distress caused to her by the lack of adequate communication. The Ombudsman also recommended that the Health Board provides evidence that it has learnt from the communication shortcomings identified and undertakes a refresher training session regarding the appropriate monitoring of patients, to the Health Board staff who cared for Mr P during the bank holiday weekend. The Health Board agreed to these recommendations.

[Hywel Dda University Health Board – Clinical treatment in hospital](#) [Case number 201702721 – Report issued in September 2018](#)

Miss T complained that the care and treatment afforded to her in response to a suspected deep vein thrombosis ("DVT") in her leg, both during and after her pregnancy, was inadequate. Miss T also complained that Hywel Dda University Health Board's ("the Health Board") decision, not to admit her postnatally to a maternity ward with her baby for treatment, was unreasonable.

The Ombudsman was unable to provide a robust response to Miss T's complaint that her treatment during pregnancy was inadequate, as the Health Board were unable to provide her medical records from this admission. This element of Miss T's complaint was upheld. The Ombudsman recommended that the Health Board apologised to Miss T for the record loss and acts to prevent a similar incident reoccurring. The Health Board agreed to these recommendations.

The Ombudsman was satisfied that Miss T's postnatal care and treatment was appropriate, and that Miss T did not have a DVT in her leg at any stage of her treatment. This element of Miss T's complaint was not upheld.

The Ombudsman was unable to make a finding in relation to Miss T's complaint that she should have been readmitted, postnatally, to a maternity ward with her baby for treatment, as he was unable to obtain the personal information required that would need to be considered to make conclusions on this element of Miss T's complaint.

[Powys Teaching Health Board & Wye Valley NHS Trust – Other](#) [Case number 201701007 & 201706029 – Report issued in September 2018](#)

Mrs C complained about the way Powys Teaching Health Board ("the Health Board") and Wye Valley NHS Trust ("the Trust") treated her referral for surgery. Mrs C said that they did not undertake the surgery within a reasonable amount of time and that the Trust did not action a concern from her GP practice about the amount of time it was taking for surgery to be arranged. Mrs C also said the Health Board did not fully consider her request for funding an alternative provider and that the Health Board did not properly investigate her complaint. Mrs C sought some reimbursement of the cost of private treatment

The Investigation found that Mrs C was appropriately graded as routine by the Trust and the date that was offered for surgery would have fallen only a few days outside of the Welsh Government target time for referral to treatment. In any event, Mrs C received her private surgery before the target could be breached.

The Investigation found that the Health Board provided Mrs C and her GP practice with information on how she could seek to expedite her treatment if her clinical condition had changed, and she now believed she should be treated urgently. This advice was not followed, and Mrs C instead sought private treatment.

The Investigation did partially uphold Mrs C's complaint about the way her complaint was handled and communication with Mrs C. The Ombudsman found that the Health Board had not provided Mrs C with clear advice on how long it was likely to be before she underwent the operation, and this contributed to Mrs C's decision to receive private treatment. He also found that there were missed opportunities for the Health Board to direct Mrs C to the complaints process earlier than it did, and this created some confusion for Mrs C.

[Betsi Cadwaladr University Health Board – Clinical treatment in hospital](#)
[Case number 201702648 – Report issued in September 2018](#)

Mrs X complained that her husband, who had longstanding and worsening heart-related problems, was inappropriately moved from the Coronary Care Unit (of Ysbyty Gwynedd) to a gastroenterology ward and he did not, as a result, receive the palliative care he needed. Mrs X complained that the family should have been made aware sooner that Mr X was at the "end of life" stage of his illness. Mrs X was aggrieved that the Consultant Cardiologist responsible for Mr X's care had implied that he had had a discussion with them over a weekend, which they denied happened. Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to provide her with a copy of a statement prepared by one of the nurses involved in Mr X's care.

The investigation found that moving Mr X to the gastroenterology ward had been inappropriate, considering his condition, and that there had been an unacceptable delay in involving the palliative care team in his care. Mrs X had asked for a copy of the statement in question during the local resolution meeting, but the Health Board failed to action that request. These complaints were upheld. The complaint regarding whether a discussion had taken place over the weekend was not upheld.

It was recommended that the Health Board should apologise to Mrs X for the failings found, ensure that lessons were learned from this case, offer a copy of the statement to Mrs X, undertake an audit to ensure that the policy restricting the movement of patients with certain conditions was being observed and provide evidence that palliative care training had been undertaken at the Hospital. The Health Board agreed to implement the recommendations.

Not upheld

[Cardiff and Vale University Health Board – Clinical Treatment in Hospital](#)
[Case number 201702780 – Report issued in July 2018](#)

Mr Y complained that his late father Mr X's cancer should have been identified earlier. Mr Y complained that surgical intervention had not been considered for his father because of his age (90 years).

The Ombudsman found that surgical intervention had not taken place because of Mr X's general fitness and medical problems, rather than his age. He also found that there was no criticism of Mr X's treatment and observations. The Ombudsman found that Mr X's cancer could not have been identified any earlier than 19 August. The Ombudsman did not uphold Mr Y's complaint.

[Cwm Taf University Health Board – Clinical Treatment in Hospital](#)

[Case number 201702835 – Report issued in July 2018](#)

Mrs P complained that, between 28 May and 19 August 2016, the Health Board failed to diagnose her Postural Tachycardia Syndrome (“POTS”), a condition which causes an abnormal increase in heart rate after sitting up or standing. POTS typically causes dizziness and fainting related to altered blood flow to the brain and other associated symptoms, which Mrs P complained Cwm Taf University Health Board (“the Health Board”) did not treat and manage appropriately.

The Ombudsman found that the Health Board undertook appropriate investigations into Mrs P’s symptoms, and there was no evidence of delay or carelessness on the part of any of the clinicians involved in her care. He did not uphold any element of the complaint.

[Cwm Taf University Health Board – Clinical Treatment in Hospital](#)

[Case number 201702718 – Report issued in July 2018](#)

Mrs J complained about the care and treatment she received from Cwm Taf University Health Board (“the Health Board”) during her pregnancy, which, sadly, ended in her baby daughter being stillborn on 3 February 2016. Mrs J was aggrieved that there was a failure to spot static growth at 36 weeks of pregnancy. Mrs J also complained that measurements were not taken during a visit to the antenatal clinic on 28 January when her baby was found to be in the breech position (when the baby is lying bottom first or feet first in the womb instead of in the usual head first position).

The Ombudsman found there was no evidence to indicate that a growth scan was indicated at 36 weeks of pregnancy and did not uphold this element of the complaint. In relation to Mrs J’s complaint that measurements were not taken on 28 January, the Ombudsman did not find any evidence to suggest there were grounds for clinicians to be concerned about foetal growth at the time. He noted that when further measurements were taken on 2 February there had been continued foetal growth since the previous measurements taken on 17 January. The Ombudsman did not consider there was a failing on the part of the Health Board in not recording SFH measurements on 28 January and did not uphold the complaint.

[A GP practice in the area of Betsi Cadwaladr University Health Board – Clinical Treatment outside Hospital](#)

[Case number 201702443 – Report issued in July 2018](#)

Mrs A complained that a GP Practice (“the Practice”) in the area of Betsi Cadwaladr University Health Board, failed to provide appropriate care and treatment for her mother, Mrs D, between 12 May 2015 and 6 April 2016, which led to a delayed diagnosis of lung cancer.

The complaint was not upheld. The Ombudsman concluded that the Practice had acted reasonably in considering and treating Mrs D’s symptoms and that there did not appear to be any evidence that Mrs D’s cancer could have been identified earlier.

[A dental practice in the area of Powys Teaching Health Board – Clinical treatment outside hospital](#)

[Case number 201702361 – Report issued in July 2018](#)

Mrs V complained that the care and treatment provided to her by the Dental Practice was inadequate. She specifically complained that, in response to her presenting symptoms, she was only offered a denture and that no other alternative NHS or private treatment options were discussed with her. Mrs V also complained that, when she received the denture, she was unable to wear it as it was ill-fitting.

Whilst the Ombudsman could not determine if different treatment options had been explained to Mrs V during her appointments at the Dental Practice, he was satisfied that a denture was the only suitable treatment option available to her in response to her presenting symptoms. This element of Mrs V's complaint was not upheld.

In consideration of whether the denture was ill-fitting, the Ombudsman found that the Practice made adjustments to the denture and that, whilst it was unfortunate that Mrs V was unable to wear the denture, there was no evidence that this was because the denture had been poorly made. This element of Mrs V's complaint was also not upheld.

[Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital](#) [Case number 201706059 – Report issued in July 2018](#)

Mrs D complained that clinicians at Abertawe Bro Morgannwg University Health Board ('the Health Board') failed to fit her daughter, Ms C, with an Implantable Cardioverter Defibrillator¹ (ICD) and that Ms C's death could have been prevented had they done so.

The complaint was not upheld. The Ombudsman found that, with the benefit of hindsight, had Ms C been fitted with an ICD, it might have prevented her death. However, the decision made not to fit Ms C with an ICD was appropriate and in line with clinical guidance, based on Ms C's clinical condition at the time and the risks associated with fitting an ICD.

[Cwm Taf University Health Board – Appointments/ admissions/ discharge and transfer procedures](#) [Case number 201607748 – Report issued in July 2018](#)

Mrs X complained that there had been a lack of intervention and support from mental health services for her son, Mr Y. Mrs X considered that Mr Y was neglected in the community when he was clearly unwell and in a manic state. She felt he suffered unduly as a result. She said he had completely lost his dignity when his predicament may have been avoided with earlier intervention and support.

Mrs X was aggrieved that Cwm Taf University Health Board's ("the Health Board") complaint handling was poor. Mrs X said that she wasn't provided with answers to her questions about the care provided to her son despite having attended meetings with Health Board staff about the matter.

The investigation found that Mr Y was not neglected in the community by mental health services when he was unwell, and the service did strive to provide sufficient, adequate and appropriate intervention and support. The investigation also found that the Health Board's response to the complaint made against it had not been unreasonable, in the circumstances.

The complaints were, therefore, not upheld.

[Abertawe Bro Morgannwg University Health Board – Health](#) [Case number 201704084 – Report issued in August 2018](#)

Ms X complained about the cardiac care given to her partner, Mr Y, by Abertawe Bro Morgannwg University Health Board ("the Health Board"). She indicated that the Health Board should have placed Mr Y's name on its urgent, and not its routine, waiting list for heart surgery and a related procedure. She also said that the Health Board had failed to advise Mr Y of what he should do if his condition deteriorated while he was waiting for surgery.

The Ombudsman found that the Health Board had prioritised Mr Y's treatment appropriately. He did not uphold the prioritisation part of Ms X's complaint as a result. The Ombudsman could not determine, without independent corroborative evidence, that the Health Board had given Mr Y advice about what to do if his condition worsened. However, he did not uphold the advice aspect of Ms X's complaint because he was unable to conclude that Mr Y had suffered an injustice because of this potential failing.

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

[Case number 201702689 – Report issued in August 2018](#)

Ms X complained about the treatment provided to her six-year-old daughter, Y, when she attended the Emergency Department ("the ED") of Wrexham Maelor Hospital on 25 November 2016. Ms X said that a laceration to Y's forehead should have been stitched, as opposed to closed with medical glue.

The Ombudsman found that the decision made by the ED Consultant to clean and glue the wound to Y's forehead was reasonable and appropriate and in line with relevant guidelines. The complaint was not upheld.

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

[Case number 201704823 – Report issued in August 2018](#)

Mr and Mrs A complained that there had been a failure to diagnose their daughter, Baby B with Ventricular Septal Defect ("VSD") prior to her discharge from hospital in May 2017.

Whilst the Ombudsman found that Cwm Taf University Health Board's monitoring and reviewing of Baby B would have been better, the investigation could not establish any impact upon Baby B's prognosis. The complaint was therefore not upheld.

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

[Case number 201705057 – Report issued in August 2018](#)

Ms X complained to the Ombudsman about the treatment that she received from Cwm Taf University Health Board. Ms X said that the clinicians made a 'best interests' decision not to inform her of the Local Authority's decision to issue care proceedings following the birth of her baby.

The investigation found that the decision taken had been one of professional judgement, not a 'best interest' decision. Ms X and her unborn baby's health were at the forefront of the clinician's decision making and the decision taken was reasonable in the circumstances. The complaint was, therefore, not upheld.

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

[Case number 201706197 – Report issued in August 2018](#)

Mrs D complained that she waited too long for orthopaedic surgery and that, had Betsi Cadwaladr University Health Board ("the Health Board") applied its procedures properly in her case, she would have received her surgery at an earlier date and it may not have been as complex.

The investigation found that all patients waiting for the same surgeon experienced a similar delay and so were equally adversely affected. Furthermore, there was no evidence to suggest that Mrs D's case was inappropriately graded as routine or that the surgery she received was more complex because of the delay. Finally, Mrs D had been offered surgery with a different surgeon which would have reduced her waiting time but decided not to accept that offer. The complaint was not upheld.

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

[Case number 201703379 – Report issued in September 2018](#)

Miss A complained about the procedure undertaken by Aneurin Bevan University Health Board (“the Health Board”) for her chronic knee pain. Miss A complained that the treatment was inappropriate, a lack of follow up appointments, and that she was not properly informed of the risks associated with the procedure. Miss A considered the Health Board’s complaints response was biased in the clinician’s favour and contained factual inaccuracies.

The investigation found that there was no fault in the Health Board’s care provided to Miss A in respect of the procedure. The investigation was unable to reach a definitive view on what was said and/or understood by the respective parties about the risks associated with the procedure due to the differing version of events provided. No finding could be reached on this aspect; however, it was concluded that no clinical harm was caused to Miss A by the procedure itself, or from a complication of that procedure.

Finally, the investigation concluded that the Health Board’s complaint response appropriately addressed the issues raised in Miss A’s complaint. Based on all the available evidence, Miss A’s complaints were not upheld.

[GP Surgery in the area of Hywel Dda University Health Board – Clinical treatment outside hospital](#)

[Case number 201706625 – Report issued in September 2018](#)

Mrs Y complained about the treatment her late father Mr X received from a GP on 2 August 2016. Sadly, on 3 August Mr X died, his cause of death was recorded as sepsis due to a community acquired pneumonia. Mrs Y said that the GP at her father’s home visit had not identified the seriousness of his condition or taken into account his underlying blood condition. Mrs Y said that had further weight been given by the GP to her father’s condition and it might have led to a different outcome for him.

The Ombudsman had no criticism of the GP’s examination of Mr X and the diagnosis of probable chest infection. The Ombudsman found that the GP had not conducted a CRB65 severity assessment (“the CRB65-a point awarded for each of the following - confusion, raised respiratory rate, low blood pressure and aged over 65 years, a score of zero - low risk, one or two – intermediate risk, three or four – high risk”) or considered a hospital admission for Mr X. He found that even had Mr X been admitted to hospital after the GP’s visit it would not have affected the outcome and the complaint was not upheld. The Ombudsman invited the Practice to consider its policy on implementing the CRB65. The GP Practice has adopted access for GPs at consultations and home visits to the CRB65.

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

[Case number 201706625 – Report issued in September 2018](#)

Miss M complained that Cardiff and Vale University Health Board (“the Health Board”) failed to recognise that her partner, Mr A, was suffering from metastatic cancer (cancer that has spread from where it first formed to other parts of the body, forming new tumours) and take appropriate action to treat the disease.

The Ombudsman found that the Health Board gave due thought to Mr A’s wishes, and that ultimately the decision to monitor his condition with serial imaging was within the bounds of reasonable clinical practice. He found that there was a delay in carrying out diagnostic thoracic surgery, which was not explained, however, this delay did not materially affect Mr A’s condition or the course of his disease as it progressed. Therefore, the Ombudsman did not uphold the complaints.

Hywel Dda University Health Board – Clinical treatment in hospital Case number 201706145 – Report issued in September 2018

Mr A complained about the care and treatment his wife Mrs A received following knee replacement surgery on 22 August 2017 at Bronglais General Hospital. He expressed concern that his wife was discharged too soon after the surgery despite having an infection which subsequently worsened and required further hospital admission.

The Ombudsman's investigation concluded that Mrs A's care and management was reasonable and appropriate. He noted however that whilst it was far from ideal that Mrs A required further hospital admission, he was satisfied from the evidence considered that the infection that Mrs A suffered subsequent to her discharge was an unfortunate but recognised complication of the surgery. He did not uphold Mr A's complaint.

GP Practice in the area of Betsi Cadwaladr University Health Board – Clinical treatment outside hospital Case number 201704800 – Report issued in September 2018

Mrs S complained to the Ombudsman about the care provided to her late mother, Mrs X, by her GP ("the GP"). She complained that the GP had failed to provide Mrs X with appropriate antibiotic treatment for a chest infection. She also complained that the GP had refused to visit her mother and disputed that he was on annual leave at the time the visit was requested.

The Ombudsman found that there was no evidence within the GP records that Mrs X had a chest infection during the period in question and that there was no indication that the GP should have provided antibiotic treatment for a chest infection. The GP Practice also provided compelling evidence to support the fact that the GP was on holiday at the time Mrs S requested that he visit her mother. Accordingly, the Ombudsman did not uphold the complaint.

GP Practice in the area of Hywel Dda University Health Board – Clinical treatment in hospital Case number 201707339 – Report issued in September 2018

Ms X and Mrs Y complained to the Ombudsman about the care and treatment afforded to their late father, Mr Z, by the Nurse Practitioner based within the GP Practice on 30 June 2017. In particular, they complained about the nature of the examination at the consultation and the subsequent diagnosis. Mr Z suffered a cardiac arrest and sadly died a few weeks later.

Whilst the investigation identified that an abdominal examination should have been undertaken, and explorative questions regarding the pain asked during the consultation, it was unlikely that the additional investigation and examination would have resulted in a suspicion of a cardiac cause of Mr X's reported symptoms. The investigation concluded that the failings identified did not cause Mr Z, Ms X nor Mrs Y to suffer an injustice. The complaint was not upheld.

Dental Practice in the area of Cardiff and Vale University Health Board – Clinical treatment outside hospital Case number 201703972 – Report issued in September 2018

Mrs A complained about the care and treatment she received from a dentist ("the Dentist") in January and February 2017. In particular, she complained that the Dentist removed a tooth without her consent.

The Ombudsman's investigation found that overall the care provided to Mrs A was reasonable and appropriate and therefore did not uphold this aspect of Mrs A's complaint. He was also satisfied that on balance the treatment options were discussed with Mrs A and that she consented to the treatment. Again, he did not uphold this part of Mrs A's complaint.

Early Resolution and Voluntary Settlement

Betsi Cadwaladr University Health Board – Clinical Treatment in Hospital

Case number 201801417 – Report issued in July 2018

Mr H complained about the failure of Betsi Cadwaladr University Health Board (“the Health Board”) to respond to his claim since October 2017. Although the Health Board had apologised for the delay there was no set response date. The Ombudsman decided that he would not investigate the complaint at this time, however, the Health Board was contacted regarding the delay.

The Health Board agreed to take the following step to settle the claim:

- a) Apologise and respond to the complaint by 31 July 2018

Aneurin Bevan University Health Board – Appointments/ admissions/ discharge and transfer procedures

Case number 201800717 – Report issued in July 2018

Miss T complained that Aneurin Bevan University Health Board (“the Health Board”) had falsified her medical records to indicate that she had failed to contact its booking centre to arrange an outpatient appointment at its Ear, Nose and Throat Department. She requested that the Board amended its records and advised her local Surgery to correct any misinformation.

The Ombudsman considered the information submitted to his office and found that there had been an error by the booking centre. It contacted the Board which agreed to:

- a) Write a letter of apology to the complainant explaining the error in issuing the incorrect reasons on the letter from the Bookings department in March 2018.
- b) Provide a copy of a letter the Board intends to send to her GP correcting the information originally provided and requesting that it be removed from her medical records.
- c) Provide her with reassurance that her name will not be placed on any list of “non- attendees” at appointments and that no such list is in existence.

This should be provided within 20 working days of the date of my decision letter.

Powys Teaching Health Board – Clinical Treatment in Hospital

Case number 201800998 – Report issued in July 2018

Mrs X complained that for a period of approximately eleven years, her child had suffered various health issues which were misdiagnosed and mistreated. She complained to the Health Board in March 2017 but at the time of bringing her complaint to the Ombudsman, she had not received a response.

The Ombudsman contacted Powys Teaching Health Board (“the Health Board”). The Health Board advised that the matter had been considered by a Redress Panel in September 2017, but the outcome had never been communicated to Mrs X.

The Health Board had recently met with Mrs X to express its apologies and explain the outcome. It had also agreed to undertake the following actions:

- a) Provide a written response within 30 days after the meeting.
- b) Offer £250 in recognition of the delay in communicating its outcome.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case number 201801195 – Report issued in July 2018

Mr X complained that Cardiff and Vale University Health Board (“the Health Board”) failed to diagnose his late father’s tumour. Mr X believed that had the tumour been diagnosed, the appropriate treatment would have been provided, and his father still alive.

The Ombudsman recognised that Mr X had been offered, and had attended, a meeting with the Health Board, and been supplied with a recording of that meeting. A formal Putting Things Right (“PTR”) response, in line with PTR Regulations, had, however, not been issued.

The Health Board apologised for this oversight, assured the Ombudsman that its staff had been reminded of their duty to issue a PTR response. It asked for an opportunity to apologise to Mr X and his family directly. The Health Board also assured the Ombudsman that a PTR response would be sent by 31 July 2018. The Ombudsman considered this to be a reasonable resolution of the complaint.

Betsi Cadwaladr University Health Board – Other

Case number 201706736 – Report issued in July 2018

Ms B complained that Betsi Cadwaladr University Health Board (“the Health Board”) failed to supervise and/or assist her late father, Mr C, when he was trying to give a urine sample. She indicated that she was dissatisfied because the Health Board did not interview Mr C, or other members of his family, when investigating the circumstances surrounding Mr C’s related fall. She also complained that it did not give her information about that investigation.

The Ombudsman noted that the Health Board had not addressed the issue of qualifying liability,¹ in accordance with the ‘Putting Things Right’ (“PTR”) arrangements,² when responding to Ms B’s complaint. Ms B confirmed that she wanted the Ombudsman to refer her complaint back to the Health Board for further consideration as a result. The Ombudsman obtained the Health Board’s agreement to:

- a) Send Ms B a further written response to her complaint, which addresses the issue of qualifying liability, in accordance with the PTR arrangements.

He then referred Ms B’s complaint back to the Health Board. The Ombudsman considered, consequently, that Ms B’s complaint had been settled.

GP Surgery in the area of Abertawe Bro Morgannwg – Health

Case number 201801667 – Case issued in August 2018

Mrs H complained that a GP Practice (“the GP Practice”) in the area of Abertawe Bro Morgannwg stopped prescribing her mother medication including Thyroxine which she needed due to having both her thyroid glands removed. Mrs H explained that neither the GP Practice nor the Care Home, where her mother lived informed her that they had stopped her mother’s medication. The Ombudsman found that the GP Practice, knowing that her mother had Alzheimer’s and was in a care home, should have considered Mrs H and her father as suitable people to make a complaint.

The GP Practice agreed to undertake the following action, within 6 weeks of the day of the Ombudsman’s decision, in settlement of the complaint:

- a) Apologise and issue a formal complaint response letter

Cardiff and Vale University Health Board – Health

Case number 201802054 – Report issued in August 2018

Mr X complained about his care and treatment whilst a patient at a hospital under Cardiff and Vale University Health Board (“the Health Board”) in early 2015, when he had contracted infections and other illnesses following neurological procedures. This had resulted in a complex recovery. Having pursued complaints with the Health Board, Mr X also complained that he had not received a reply to his most recent letter sent in April 2018.

Having considered the evidence before him, the Ombudsman declined to investigate the substantive issue. It was significantly out of time as the Health Board had first responded to Mr X’s complaint in July 2015. Since, Mr X had been in consultation with solicitors, with a continued express intent to pursue a legal claim. The Ombudsman also considered there to be another remedy reasonably available to him.

The Ombudsman found that no reply had been sent to Mr X’s latest letter, and so contacted the Health Board. It agreed to do the following, as a resolution of the complaint, within 14 days:

- a) Write to Mr X to offer to facilitate a meeting to discuss the outstanding concerns set out in his (unanswered) letter
- b) Write to Mr X to offer to instruct an independent clinical expert to review the care delivered to him.

GP Surgery in the area of Hywel Dda University Health Board – Health

Case number 201801770 – Report issued in August 2018

Mr D complained that a GP Surgery (“the GP Surgery”) had failed to diagnose and take appropriate action when presented with symptoms of his late wife’s illness. She had suffered with Chronic Obstructive Pulmonary Disease for many years. He complained that the GP Surgery had failed to consider that swelling to her legs and feet was an indication of Cor Pulmonale, which she was later diagnosed as suffering with before she sadly passed away.

The Ombudsman found that the Hywel Dda University Health Board (“the Board”) had not considered the complaint under its Putting Things Right (“PTR”) complaints process. It contacted the Board and it agreed to:

- a) Write a letter to Mr D confirming that it will consider his complaint in line with its PTR process.

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

GP Practice in the area of Hywel Dda University Health Board – Health

Case number 201802274 – Report issued in August 2018

Mrs X complained about the care and treatment provided to her late mother by a GP Practice (“the GP Practice”) in the area of Hywel Dda University Health Board (“the Health Board”). Mrs X also had concerns about the way in which the GP Practice communicated with her family, and about the Health Board’s handling of her complaint.

The Ombudsman considered that the substantive issues regarding the care provided by the GP Practice was out of time for investigation by his office. However, it appeared from the information provided that the Health Board did not have full regard for the “Putting Things Right” Regulations when responding to Mrs X’s complaint. Additionally, Mrs X’s family felt that it had not received a genuine apology from the GP Practice.

Therefore, the Health Board agreed to complete the following actions by 9 October 2018:

- a) Apologise for the complaint not being properly considered in accordance with the Putting Things Right Regulations
- b) The GP Surgery to apologise directly to Mrs X for the deficiencies identified in the Health Board's report.

Abertawe Bro Morgannwg University Health Board – Health Case number 201802462 – Report issued in August 2018

Ms X complained that her father died as a result of poor clinical judgement of hospital staff under Abertawe Bro Morgannwg University Health Board ("the Health Board") and its failure to diagnose and provide the treatment to a reasonable standard. She complained that the staff were rude and did not act in a professional manner.

Ms X also complained of the Health Board's handling of her complaint, that it failed to communicate with her and she had still not received a response to a complaint she raised in August 2017.

The Ombudsman contacted the Health Board to obtain its comments and was advised that its investigation was complete. Its final report and letters had been passed to the Nurse and Medical Director to ensure the information contained within them was accurate.

It agreed with the Ombudsman that the final documents would be issued to Ms X no later than 31 August 2018.

Aneurin Bevan University Health Board – Health Case number 201801566 – Report issued in August 2018

Mrs J complained about the extensive delays and poor communication she experienced after making a complaint to Aneurin Bevan University Health Board ("the Health Board") in February 2017. Following an initial complaint acknowledgement on 17 February 2017, communication was sporadic and required much chasing by Mrs J's solicitors. This resulted in Mrs J bringing a complaint to the Ombudsman's office concerning the Health Board's communication and complaint handling.

Upon assessing the information available, the Ombudsman felt that there was an opportunity for the matter to be resolved in a manner which was agreeable to all parties. Aneurin Bevan University Health Board agreed to undertake the following action in settlement of Mrs J's complaint:

- a) A payment of £250 to be made to Mrs J (by 1 September 2018) by way of redress for the prolonged wait she had endured.

Abertawe Bro Morgannwg University Health Board – Health Case number 201801787 – Report issued in August 2018

Miss X complained about the care and treatment provided to her father from his admission to hospital in March 2013 until his death in May 2013. Miss X believed that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to provide an acceptable standard of care as her father had a fairly good quality of life before the fall that led to his hospital admission. Miss X was also concerned that the Health Board had failed to deal with her complaint in an appropriate and timely matter in accordance with its formal complaint's procedure. In particular, she said that the Health Board had not given sufficient consideration to whether 'qualifying liability'¹ arose in relation to the care provided or in terms of appropriate redress.

The Ombudsman concluded that the aspects of the complaint that related to the care and treatment provided by the Health Board were out of time for consideration by his office. However, there were some aspects of the complaint that were within time and related to the Health Board's handling of Miss X's original complaint. Because of this, the Ombudsman contacted the Health Board and it agreed to carry out the following, within one month, in settlement of this aspect of the complaint:

- a) Provide Miss X with a final response to set out the Health Board's position on whether a breach of duty had occurred and if qualifying liability was admitted

[Aneurin Bevan University Health Board – Health Case number 201801998 – Report issued in August 2018](#)

Ms X, who is a solicitor, complained about the delay by Aneurin Bevan University Health Board ("the Health Board") in responding to correspondence on a client's complaint, which she had sent to them on 22 January 2018.

From the papers Ms X provided, the substance of her client's complaint related to the care and treatment she received from medical staff in May 2017. Ms X first wrote to the Health Board on 08 September 2017 about the complaint, and the Health Board replied under 'Putting Things Right' on 04 December 2017. Ms X then wrote again, raising some further questions, on 22 January. The Health Board acknowledged this on 24 January and indicated a reply could be expected by 24 March. However, despite chasing correspondence and holding letters being exchanged which repeatedly indicated a reply would be sent 'shortly', the Health Board had not provided a substantive reply.

The Health Board agreed to:

- a) Provide the complaint response to Ms X by 20 August 2018;
- b) Apologise for the delay in providing the response; and
- c) Review the management of the complaint.

[Betsi Cadwaladr University Health Board – Health Case number 201800923 – Report issued in August 2018](#)

Ms Y complained that there had been a significant delay of ten years before Betsi Cadwaladr University Health Board ("the Health Board") diagnosed her son ("Child X") with Inconsistent Speech Disorder ("ISD"). She explained that, since the diagnosis was made, Child X's Speech and Language Therapy provision had been adapted to meet his needs better, and that as a result his speech and communications skills are improving.

The Ombudsman found that, whilst the Health Board had issued a response to the complaint, it had not fully addressed Ms Y's concerns. However, the Health Board had subsequently appointed an Independent Therapist to reconsider Ms Y's complaint. The Health Board agreed to issue its final response by 17 August 2017, and to ensure that it addressed Ms Y's outstanding concerns that:

- a) Despite it being established by 2011 that Child X's hearing impairment was not significant enough to be affecting his speech, his ISD was not diagnosed until in 2017, when Ms Y enquired about a further assessment
- b) Child X's care and support would have been different, and his speech could have been better improved, if the diagnosis had been known earlier.

Hywel Dda University Health Board – Health Case number 201801771 – Report issued in August 2018

Mrs B complained that she had experienced significant delays in receiving total right hip replacement surgery under Hywel Dda University Health Board (“the Health Board”), which resulted in increased and prolonged pain and subsequent complications. Mrs B said that she was referred to a Hospital Consultant, who advised her in August 2015 that she would be placed on the “urgent” waiting list for surgery, but she did not undergo the operation until November 2016. Mrs B also complained about the way the Health Board handled her complaint.

The Ombudsman found that the Health Board’s response was issued 11 months after Mrs B’s complaint was first raised, which constituted an unacceptable delay. Furthermore, it failed to respond to the crux of Mrs B’s complaint or consider whether the extended delay from the referral to the time of her operation represented a breach in its duty of care.

The Health Board agreed to undertake the following actions, within four weeks of the Ombudsman’s decision, in settlement of the complaint:

- a) Apologise for the delay, and for failing to respond to all the issues Mrs B raised in her initial complaint letter
- b) Offer Mrs B £500 in recognition of her time and trouble, and the complaint handling failures identified
- c) Provide a full response to Mrs B’s complaint about the length of time she had to wait following the initial referral in June 2015.

Abertawe Bro Morgannwg University Health Board – Health Case number 201801021 – Report issued in August 2018

Mrs A complained about aspects of her late husband’s management including resuscitation during his last admission at the Abertawe Bro Morgannwg University Health Board’s (“the Health Board”) Princess of Wales Hospital.

The Health Board agreed to review against the National Institute for Health and Care Excellence’s guidance how it had dealt with the issue of resuscitation in Mr A’s case. This was to enable it to reflect on whether there were areas for improvement.

Cardiff and Vale University Health Board – Health Case number 201704401 – Report issued in August 2018

Mr A complained to the Ombudsman that the hospital transport provided to their late son by Cardiff and Vale University Health Board (“the Health Board”) was inappropriate and not equipped to deal with his needs. During the investigation, the Health Board proposed a settlement which the Ombudsman considered reasonable to settle the complaint.

The Health Board agreed to:

- a) Within one month apologise to Mr A for the distress caused by the transportation and acknowledge that other options could have been explored
- b) Within three months, review the way in which patients are assessed for return journeys from the Day Surgery Unit, including documenting the options available along with any limitations and making sure these are explained to the patient and family.

The Ombudsman was pleased to note the action that the Health Board had taken to settle the complaint.

Abertawe Bro Morgannwg University Health Board – Health Case number 201801021 – Report issued in August 2018

Mrs X complained to the Ombudsman about a failure by Abertawe Morgannwg University Health Board (“the Health Board”) to identify that her husband had fractured his hip, compromising his rehabilitation following the amputation of a part of his leg. Mrs X considered that the Health Board should not have discontinued her husband’s rehabilitation following the fracture and was concerned that his treatment and support following the identification of the fracture was inadequate.

Following the commencement of the Ombudsman’s investigation the Health Board reviewed Mr X’s care and identified that it had breached its duty of care towards Mr X in that it had not performed an X-ray of Mr X’s hip after he had attended a rehabilitation appointment, having reported a fall and complaining of pain.

The Health Board offered that Mr X could engage with the redress element of the “Putting Things Right” process and that he be given the opportunity to have free legal advice (from a list of accredited solicitors) and access to independent clinical advice in order to determine whether there was redress liable to him for the identified breach in the Health Board’s duty of care. 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.

Betsi Cadwaladr University Health Board – Health Case number 201801466 – Report issued in August 2018

Mrs A complained about the care and treatment afforded to her late mother in hospital from October to December 2017. Further, that she had not been informed that a Safeguarding referral had been made and that her mother’s discharge was unnecessarily delayed.

Although the Ombudsman declined to investigate Mrs A’s complaint, he recognised that Betsi Cadwaladr University Health Board (“the Health Board”) had failed to inform Mrs A of the lessons learned in relation to how staff had communicated with her about her mother’s Safeguarding needs and how this may have delayed her discharge. Further, that the Health Board’s complaints response contained slightly misleading information about the initial Safeguarding referral and why a subsequent referral had to be made. In its complaint’s response, the Health Board identified that there was no documentation to explain changes to Mrs A’s mother’s skin, for which it provided an explanation and an apology, but it did not indicate that any action had been taken in response to this.

Because of this, he contacted the Health Board and it agreed to do the following within one month:

- a) To provide Mrs A with a full apology and explanation of the Safeguarding referral and information about the lessons learned in relation to communicating the Safeguarding needs of her mother with her.
- b) To offer Mrs A a redress payment of £50 in recognition of the failure to provide this information.
- c) To consider whether any record keeping concerns can be addressed with relevant staff members.

Hywel Dda University Health Board – Health Case number 201801503 – Report issued in August 2018

Mr Y complained to the Ombudsman that Hywel Dda University Health Board (“the Health Board”) incorrectly invoiced his wife for NHS treatment as an overseas visitor. Mr Y complained that the Health Board referred the case to a debt collection agency whilst the invoice was in dispute and before it had received advice and clarity from Welsh Government on his wife’s liability to pay the charges. Mr Y complained that the Health Board did not respond to one of his complaint letters.

Although the Ombudsman declined to investigate Mr Y's complaint, he recognised that following dispute of the original invoice in January 2018, the Health Board had amended the total charges, but it had failed to adequately acknowledge and apologise for its error. Further, that the Health Board had passed the case to a debt collection agency whilst the invoice continued to be in dispute and prior to receiving Welsh Government advice. The Ombudsman clarified that the dispute is ongoing and that the Health Board is yet to provide a definitive decision on this case, dependent on information provided by Mr Y.

The Ombudsman contacted the Health Board and in addition to providing Mr Y with a final decision in relation to the invoice, it agreed to do the following within one month:

- a) Provide a full written apology to Mr Y for the uncertainty and distress caused from the original invoice and for referring his case to a debt collection agency, whilst the invoice was in dispute and whilst awaiting clarification from Welsh Government.
- b) To provide Mr Y with a redress payment of £125, in recognition of the time and trouble taken to raise his concerns and to receive a definitive response.

GP Practice in the area of Aneurin Bevan University Health Board – Health Case number 201801382 – Report issued in August 2018

Mr A complained to the Ombudsman about an incident at a GP Practice ("the GP Practice") in the area of Aneurin Bevan University Health Board ("the Health Board") regarding a medication prescription. Mr A said his medication was stopped without consultation and when he tried to complain staff were obstructive. Mr A said the Practice failed to address his concerns and he felt discriminated against. He also said it copied a letter about his behaviour to the Community Health Council, but he was unsure why.

Although the Ombudsman declined to investigate Mr A's complaint, he recognised the Practice's actions in respect of Mr A's medication prescription were reasonable and appropriate. However, Mr A's concerns about his complaint being obstructed had not been addressed adequately. Because of this, he contacted the Practice and it agreed to do the following within one month of the date of this decision.

- a) To provide Mr A with a written apology for not addressing all his concerns adequately.
- b) To provide Mr A with a written explanation about why a letter concerning his behaviour was copied to the Community Health Council and an apology that this was not made clear to him.
- c) Arrange to meet with Mr A to explain and clarify the Practice's policy on how a complaint can be made and discuss his concerns about staff attitude.

Cardiff and Vale University Health Board – Appointments/ admissions/ discharge and transfer procedures Case number 201802482 – Report issued in September 2018

Ms X complained about a delay in being referred for treatment to an Orthopaedic Consultant and the way in which Cardiff and Vale University Health Board ("the Health Board") managed its waiting list. Ms X subsequently paid for private treatment.

The Health Board's complaint response was issued on 26 March 2018. Ms X had two outstanding concerns following the response. As more than five months had passed since the response, and Ms X was seeking reimbursement of costs for private treatment, the Health Board agreed to complete the following action by 24 October 2018:

- a) Provide a further response to Ms X's outstanding concerns in accordance with the 'Putting Things Right' Regulations.

Cardiff and Vale University Health Board – Clinical treatment in hospital

Case number 201702850 – Report issued in September 2018

Mrs A complained about the skull fracture that her son sustained at the time of his birth in February 2017. Mrs A said that she had initially been told that a failed forceps procedure may have caused this injury. Mrs A also complained about the way in which Cardiff and Vale University Health Board (“the Health Board”) dealt with her concerns and the delays in receiving its final response. Here, Mrs A said that that she was not contacted by the Health Board on its own initiative at any point during the investigation and believed that the final response would not have been issued in July 2018 had she not consistently chased it.

The Ombudsman concluded that, as the Health Board’s final response included a report from an independent expert on the probable cause of the skull fracture, it was unlikely that an investigation by this office would achieve anything more for Mrs A. Therefore, he declined to investigate the complaint relating to her son’s injury. The Ombudsman did, however, make enquiries with the Health Board regarding Mrs A’s concerns about the handling of her complaint. Because of this, although the Health Board had already apologised to Mrs A for the lack of communication and for the prolonged delay in providing her with the final response, it agreed to carry out the following, within 20 working days, in settlement of this aspect of the complaint;

- a) Offer Mrs A £250 in recognition of the delays that she had experienced
- b) Offer Mrs A £250 in recognition of the time and trouble of her having to bring the matter to the Ombudsman

Hywel Dda University Health Board – Clinical treatment in hospital

Case number 201801052 – Report issued in September 2018

Ms P complained that Hywel Dda University Health Board (“the Health Board”) had failed to monitor her medication for five and a half years, even after she had queried it with her GP. She said that the adverse effects she experienced from the medication had been overlooked, and that her medical records contained factual inaccuracies which had not been acknowledged or addressed.

Ms P also said that the response she received from the Health Board did not address all of her concerns or explain what lessons had been learned from her case, despite seeming to acknowledge that there had been a lack of monitoring throughout that time.

The Ombudsman found that there had been some shortcomings in the Health Board’s response. The Health Board agreed to apologise to Ms P for not providing a full response under PTR and offer her £250 for her time and trouble in pursuing it. The Health Board also agreed to provide a fulsome response to the complaint which addressed all of Ms P’s concerns and confirmed the improvements that have been made to facilitate better liaison between primary care and the Health Board.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case number 201801875 – Report issued in September 2018

Mrs H complained that her husband has been in severe pain since he underwent a total knee replacement in 2016, but the cause of it has never been identified. She said that, in over a year, her husband’s knee had not been X-rayed or examined and he underwent unnecessary referrals to other departments to investigate whether the source of the pain was in his hip, or back, and that there have been inordinate delays in receiving those appointments, which have “all come to nothing”.

The Ombudsman found that during a meeting with Mr and Mrs H Abertawe Bro Morgannwg Health Board ("the Health Board") had appeared to accept that there have been significant delays in diagnosing Mr H's pain and treating the underlying cause. However, its complaints process had not been completely exhausted because it had not provided a full, written response to Mrs H and her husband, following that meeting.

The Health Board agreed to undertake the following actions, within six weeks of the date of the Ombudsman's decision, in settlement of the complaint:

- a) Apologise for not having provided a full response yet
- b) Offer £50 redress in recognition of Mrs H's time and trouble pursuing the complaint
- c) Provide a full complaint response

[Aneurin Bevan University Health Board – Other Case number 201707234 – Report issued in September 2018](#)

Mrs A complained about considerable delays and other failings by Aneurin Bevan University Health Board ("the Health Board") in progressing an Integrated Service for Children with Additional Needs' ("ISCAN") referral. Given her son's learning and behavioural issues, Mrs A was concerned about the impact the delayed referral was having on her son's education.

Shortly after Mrs A's complaint to the Ombudsman, the Health Board took action to progress the ISCAN referral. The Health Board subsequently agreed to the Ombudsman's proposals that it should:

- a) apologise to Mrs A for the failings identified
- b) make a payment to Mrs A of £750, in recognition of the distress and additional stress the referral delays had caused her and her family.

[Cardiff and Vale University Health Board – Clinical treatment in hospital Case number 201802552 – Report issued in September 2018](#)

Mr X complained that there had been a delay in the treatment of his neck and lower back injuries. Mr X also complained that there had been a failure to adequately respond to his complaint. The Ombudsman was pleased to accept Cardiff and Vale University Health Board's offer to remedy Mr X's complaint by:

- a) Paying Mr X £250 in recognition of its failure to respond to his letter regarding the cancellation of his surgery in May 2018;
- b) Paying Mr X £250 in recognition of the time and trouble he had taken in contacting this office; and
- c) Undertaking to ensure that Mr X's surgery was completed within 12 weeks of his MRI scan.

Complaints Handling

Upheld

Cardiff and Vale University Health board – Health

Case number 201705987 – Report issued in July 2018

Mrs X complained about the care and treatment that she received from Cardiff and Vale University Health Board's ("the Health Board") Orthopaedic Department. Specifically, Mrs X complained that there had been a delay in diagnosing and treating an injury to her wrist and that the Health Board had failed to adequately respond to her complaint in accordance with the "Putting Things Right" regulations.

The investigation found that, given the difficulties associated with diagnosing wrist injuries, the care and treatment received by Mrs X had been reasonable. However, the Health Board had failed to fully respond to Mrs X's complaint about the care and treatment that she received from her GP.

It was recommended that the Health Board apologise to Mrs X and pay her £500 in recognition of its failure to address her complaint and the time and trouble taken in bring her complaint to this office.

Early Resolution or Voluntary Settlement

Public Health Wales – Health

Case number 201800865 – Report issued in July 2018

Mrs A complained that she had been provided with an unreasonable patient experience at Breast Test Wales, and that the handling of her subsequent complaint, which was made to Public Health Wales, was poor.

Although the Ombudsman declined to investigate Mrs A's complaint, he was concerned that the main point of the complaint brought by Mrs A had not been addressed in the first letter sent to Mrs A by Public Health Wales, and that the second letter sent to Mrs A was confusing.

Because of this, he contacted Public Health Wales who agreed to apologise to Mrs A for not addressing her concerns as expressed in her initial complaint letter, and for any confusion caused by their second response letter.

Rhondda Cynon Taf County Borough Council – Adult Social Services

Case number 201801211 – Report issued in July 2018

Mr C complained that Rhondda Cynon Taf County Borough Council ("the Council") had not addressed safeguarding concerns about the care his late father had experienced at a privately-run Residential Home. Mr C also complained that the Council did not respond in an accurate or timely manner to his requests for information about complaining.

Although the Ombudsman declined to investigate Mr C's complaint, he was concerned that there were some issues with the communication from the Council to Mr C.

Because of this he contacted the Council who agreed to do the following within one month:

- a) To apologise for not providing a full and reasoned explanation as to why the Council would not be investigating Mr C's concerns and for providing incorrect advice in relation to the complaint process; and
- b) To provide an assurance to Mr C that information had been updated to ensure that correct advice in relation to complaints handling was provided to potential complainants.

City and County of Swansea – Various Other Case number 201800689 – Report issued in July 2018

Mr B complained that the City and County of Swansea Council (“the Council”) had failed to approve the funding for an organization Mr B was part of, which they had received annually in the past. The organization had spent money on an activity on the basis that they received funding in the past. He asked the Council to pay the invoice. Mr B also complained that the Council had failed to respond to their email about the funding and the formal complaint made thereafter.

The Ombudsman did not have the authority to investigate the financial aspects of the case as these are decisions for the Council. The Council had told Mr B that there was a strong possibility that they would not be able to fund the organization and a full application (including appropriate documents to be supported) should be sent to be considered. That was not done with any formality although Mr B send an email with a funding bid. A reply was sent to Mr B regarding the bid and formal complaint once the Ombudsman’s office contacted the Council.

Student Loans Company – Benefits Administration Case number 201800515 – Report issued in July 2018

Mr X complained that Student Loans Company (“SLC”) had failed to respond to his appeal, complaint, or enquiries regarding his disagreement with its Disabled Students’ Allowance assessment and failure to reimburse him for equipment and support services.

SLC informed the Ombudsman that it had issued correspondence to Mr X on three occasions in 2017 following his complaint. However, it did not appear that Mr X received that correspondence. The Ombudsman was not persuaded that further enquiry by his office would achieve anything further regarding the correspondence which had not been received by Mr X.

However, the information provided by SLC did not indicate that a further complaint made by Mr X in August 2017 was acknowledged or responded to, despite being received. Therefore, in settlement of Mr X’s complaint, SLC agreed to complete the following actions by 9 August 2018:

- d) Apologise for failing to respond to Mr X’s email dated 7 August 2017
- e) Issue a response to Mr X’s email
- f) Offer a payment of £250 to Mr X in recognition of the delay in responding to his email, and the time and trouble in making his complaint to the Ombudsman. Should Mr X remain dissatisfied with the response and offer of payment he should be provided with a point of contact to escalate the complaint to stage 3 of SLC’s complaint process.

Hywel Dda University Health Board – Health Case number 201801521 – Report issued in July 2018

A complaints advocate on behalf of Mr X advised that a formal complaint was first submitted to Hywel Dda University Health Board (“the Health Board”) in September 2017. Mr X complained that at the time of bringing his complaint to the Ombudsman he had still not received a response to his concerns.

After considering this complaint the Ombudsman contacted the Health Board for its comments with regards to the status of its investigation. He was advised that it had been a very complex investigation. A response had been drafted and sent to the Head of Nursing for approval. However, it was felt that further information could be provided.

On this basis, the Ombudsman considered that the Health Board's agreement to ensure that Mr X was sent the response by 31 July 2018 was a sufficient resolution of the complaint.

[Abertawe Bro Morgannwg University Health Board – Health Case number 201800114 – Report issued in July 2018](#)

Mr X and Mr Y complained to the Ombudsman that the correspondence that they had received from Abertawe Bro Morgannwg University Health Board ("the Health Board"), in response to their concerns about the care and treatment afforded to their late father during 2017, was incomplete.

The Ombudsman found that the correspondence did not address all of Mr X and Mr Y's concerns.

The Health Board agreed to the following within 30 days:

- c) Apologise to Mr X and Mr Y for failing to respond to all of the concerns raised in the original complaint letter.
- d) Provide Mr X and Mr Y with a full complaint response.

[Betsi Cadwaladr University Health Board – Complaints Handling Case number 201802216 – Report issued in August 2018](#)

Mrs B complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to put together a timely care package for her husband when he was discharged from hospital to a Care Home. This caused a delay of approximately 3 weeks. She also complained that the physiotherapist that attended to him had ended the treatment too early. She also complained that the Board had failed to meet with her after providing it as an option in its complaint response letter.

The Ombudsman contacted the Board and it agreed to;

- a) Write to Mrs B to arrange a local resolution meeting.

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

[Welsh Ambulance Services NHS Trust – Complaint Handling Case number 201801937 – Report issued in August 2018](#)

Mrs B complained that the Welsh Ambulance Services NHS Trust ("the Trust") had failed to respond to her complaint about the care provided to her late mother, Mrs C, which was made in February 2018.

The Ombudsman found that the Trust had failed to update Mrs B during the course of investigation. The Trust stated that it had written to Mrs B in July 2018 in order to obtain her consent for it to access Mrs C's records from the relevant Health Board and to submit the case to the next available Redress Panel.

The Trust therefore agreed to complete the following in settlement of Mrs B's complaint:

- a) Expedite the response to Mrs B's complaint on receipt of the relevant consent form

It also agreed to complete the following actions by 27 September 2018:

- b) Apologise for the delay in responding to Mrs B's complaint, and for the failure to keep her updated
- c) Explain the reason/s for the delay and lack of updates
- d) Make a payment of £125 to Mrs B in recognition of the delay, failure to provide updates and for the time and trouble in making her complaint to the Ombudsman.

Newport City Council – Complaints Handling

Case number 201802476 – Report issued in August 2018

Mr X complained that Newport City Council (“the Council”) had failed to respond to his complaint about a number of housing matters which the Ombudsman referred to it in March 2018.

The Ombudsman made several enquiries with the Council to obtain updates on the status of its investigation of Mr X’s complaint. Further to the Ombudsman’s enquiries, the Council subsequently agreed to undertake the following in settlement of Mr X’s complaint:

- a) Issue its response to Mr X’s complaint
- b) Apologise to Mr X for the delay in responding to his complaint

The Council completed these actions on 16 August 2018.

The Ombudsman did not consider the £50 redress payment offered by the Council to Mr X for his time and trouble in making the complaint to be sufficient given the delays.

The Council therefore agreed to complete the following action by 17 September 2018:

- c) Make a payment of £150 to Mr X in recognition of the delay in responding to him, and for the time and trouble in making his complaint to the Ombudsman.

Aneurin Bevan University Health Board – Complaints Handling

Case number 201802530 – Report issued in August 2018

Ms X complained that Aneurin Bevan University Health Board (“the Health Board”) had failed to provide its Protection of Vulnerable Adults (“POVA”) and ‘Putting Things Right’ (“PTR”) responses to her complaint which was made in August 2017 about care provided to her father.

The Health Board confirmed to the Ombudsman that it was in the process of linking both its POVA and PTR reports into one response. The Health Board therefore agreed to complete the following actions by 25 September 2018 in settlement of Ms X’s complaint:

- a) Issue the joint POVA and PTR response
- b) Apologise for the delay in responding to Ms X’s complaint
- c) Make a payment of £250 to Ms X in recognition of the delay she had experienced and for the time and trouble in making her complaint to the Ombudsman.

Hywel Dda University Health Board – Complaints Handling

Case number 201802722 – Report issued in August 2018

Mrs X complained about the care and treatment provided to her late mother by a GP Practice (“the GP Practice”) in the area of Hywel Dda University Health Board (“the Health Board”). Mrs X also had concerns about the way in which the Practice communicated with her family, and about the Health Board’s handling of her complaint.

The Ombudsman considered that the substantive issues regarding the care provided by the Practice was out of time for investigation by his office.

However, it appeared from the information provided that the Health Board did not have full regard for the Putting Things Right Regulations when responding to Mrs X’s complaint. Additionally, Mrs X’s family felt that it had not received a genuine apology from the Practice.

The Health Board agreed to complete the following actions by 9 October 2018:

- a) Apologise for the complaint not being properly considered in accordance with the Putting Things Right Regulations
- b) The GP to apologise directly to Mrs X for the deficiencies identified in the Health Board's report.

Flintshire County Council – Complaints Handling

Case number 201802838 – Report issued in August 2018

Miss X complained that Flintshire County Council ("the Council") had repeatedly failed to collect her refuse and had not responded to her email of complaint dated 17 July 2018.

The Council confirmed that it had received Miss X's complaint, but that it had been "overlooked". The Council therefore agreed to complete the following actions by 27 September 2018 in settlement of Miss X's complaint:

- a) Apologise for failing to respond to Miss X
- b) Consider and respond to Miss X's complaint under Stage 2 of its complaint's procedure.

GP Practice in the area of Hywel Dda University Health Board – Health

Case number 201801683 – Report issued in September 2018

Mr I complained that during the winter he made an appointment at the GP Practice as he needed help with his condition of anxiety and PTSD. Mr I explained that due to his anxiety he was unable to enter the Practice and although he attempted to make the appointment that he has trouble speaking on the telephone. Mr I felt discriminated against because of his condition.

The Ombudsman found that the GP Practice wrote to Mr I stating that he could nominate someone to make an appointment on his behalf. He felt this was a reasonable offer but that to assist Mr I the Practice could move matters forward.

The GP Practice agreed to undertake the following action, on receipt of the Ombudsman's decision, in settlement of the complaint:

- a) Send Mr I a letter with a suggested appointment to discuss his health.

Hywel Dda University Health Board – Health

Case number 201802868 – Report issued in September 2018

Mrs J complained that at the time of submitting her complaint to the Ombudsman, in August 2018, she had not received a response from Hywel Dda University Health Board ("the Health Board") to a complaint she had submitted in September 2017.

Upon receiving the complaint, the Ombudsman contacted the Health Board and it agreed to undertake the following in settlement of the complaint by 22 October 2018:

- a) Write to Mrs J apologising for the delay in responding to her complaint
- b) Pay £250 to Mrs J in recognition of the time and trouble in making a complaint to this office and in recognition of its delay in responding to her complaint.

The Health Board also agreed to complete the following by 30 September 2018:

- c) Issue its complaint response.

Welsh Ambulance Services NHS Trust – Health

Case number 201802977 – Report issued in September 2018

An MP complained that the Welsh Ambulance Services NHS Trust (“the Trust”) had failed to respond to the complaint he had made to it on 10 May 2018 on behalf of Ms X.

In settlement of the complaint, the Trust agreed to complete the following actions by 2 October 2018:

- a) Issue its complaint response
- b) Apologise for the delay in issuing the response.

Carmarthenshire County Council – Planning and Building Control

Case number 201803115 – Report issued in September 2018

Mr X complained that Carmarthenshire County Council (“the Council”) had failed to respond to his correspondence about a range of issues related to a new school in its area.

Mr X made a formal complaint to the Council on 1 May 2018. The Council, in responding to the Ombudsman, confirmed that it was yet to respond to Mr X’s complaint. The Council therefore agreed to complete the following actions by 10 October 2018:

- a) Issue its response to Mr X’s complaint
- b) Apologise for its complaint handling delays
- c) Explain the reason for the delays.

Isle of Anglesey County Council – Finance and Taxation

Case number 201802200 – Report issued in September 2018

Miss A complained that Isle of Anglesey County Council (“the Council”) was enforcing payment of her council tax arrears by way of deductions from her wages that were not affordable.

The Ombudsman found that the Council had not provided Miss A with the correct information for her to make an informed choice about repaying her arrears. He also found that, despite having assessed Miss A’s financial circumstances, in June 2018, it initiated deductions from her wages that it knew to be unreasonable. This caused financial hardship to Miss A. The Ombudsman contacted the Council and agreed to undertake the following actions in settlement of the complaint;

- a) apologise to Miss A for its misleading letter of 7 February 2018,
- b) refund the second attachment of earnings deducted from her wages in June and July and August 2018;
and
- c) make a redress payment to Miss A of £100 in recognition of the financial hardship caused by its failure to take account of her ability to pay.

Education

Early Resolution or Voluntary Settlement

Admissions Appeal Panel – Education

Case number 201802558 – Report issued in August 2018

Mr X complained about the administrative arrangements for the School Admission Appeal Panel (“the Panel”) hearing in respect of his daughter, Miss X, held on 25 June. There had been a procedural flaw in that on 25 June he was given an additional document by the Clerk to the Panel, which had been prepared by the Headteacher, shortly before the hearing began. Mr X complained that he had not been given sufficient time to read, consider and respond to the document prior to the Panel’s hearing. Mr X said that this was in contravention of section 4.22 of the School Admissions Appeal Code, which states that such documents should be supplied at least 7 days (5 working days) before the hearing. Despite an exchange of correspondence with the Clerk to the Panel, the Council Admissions Authority concluded that the Code had not been breached and that it was not appropriate to hold a second appeal.

The Ombudsman considered that there was sufficient prima facie evidence to indicate that there had been a breach of the Code, and that breach had caused Mr X – and Miss Y - injustice. Given that the complaint involved a School Admission Appeal, the Ombudsman felt that the most appropriate remedy in this case would be to ask the Council Admissions Authority to hold a fresh hearing of Mr X’s Appeal.

The Council Admissions Authority agreed to:

- a) Hold a fresh Appeal Panel Hearing in respect of Mr X’s appeal; and
- b) Investigate whether any other school appellants similarly affected wished to take up the offer of a fresh Appeal Panel Hearing.

Environment and Environmental Health

Not upheld

Denbighshire County Council – Noise and other nuisance issues

Case number 201702158 – Report issued in July 2018

Mrs X complained about Denbighshire County Council's ("the Council") handling of the noise nuisance complaint she raised with it about vibro-piling work being carried out on a new school development near to her home. The Ombudsman was satisfied that, overall, the Council's actions in dealing with Mrs X's complaint, were in line with its procedure. He did not uphold the complaint.

Early Resolution or Voluntary Settlement

Cardiff Council – Refuse Collection/ Recycling and Waste Disposal

Case number 201801232 – Report issued in July 2018

Mrs A complained that her waste was not consistently collected under Cardiff Council's ("the Council") "Assisted Lift"1 scheme. Mrs A also complained that when she telephoned the Council to report a missed collection, she was not able to speak to a relevant member of staff and her calls were not returned.

Although the Ombudsman declined to investigate Mrs A's complaint, he was concerned that this was the second complaint Mrs A had made to his office regarding the same issues.

Because of this he contacted the Council who agreed to do the following:

- a) To apologise to Mrs A for the failures in collecting her waste and in relation to complaints handling.
- b) To offer Mrs A a payment of £250 for the time and trouble experienced in bringing a complaint to the Ombudsman for a second time.
- c) To update Mrs A in relation to the introduction and training of staff on in-cab technology.
- d) To place a "marker" on Mrs A's address so that if further complaints were made of missed collections, the complaints handler was aware that they should update Mrs A regarding what steps would be taken to collect the missed collection.

Conwy County Borough Council – Pest Control/ Dog Nuisance/ Fouling

Case number 201707029 – Report issued in July 2018

Ms B complained that she was approached by a representative of Conwy County Borough Council ("the Council") Officer in a secluded area and advised that, as her dog was walking off lead she would be issued with a fixed penalty notice. Ms B complained about a lack of signage and being approached on private land.

Ms B paid the fine immediately and did not appeal, although she acknowledged she was aware of her right to do so. Ms B said the Officer did not advise her that he was filming the encounter and had she known this she said she would have used her right of appeal.

The Ombudsman commenced an investigation and based upon the information which came to light the Council agreed it was appropriate to settle the complaint. The Council said that within one month it would apologise to Ms B for failing to advise her that she was being filmed and pay her £100 for the time and trouble taken in pursuing her complaint.

The Council agreed to review the training provided to its officers and ensure it is satisfied that staff are aware of what to do if they are issuing a fixed penalty notice in a secluded area. The Council also agreed that the Officer should review the footage of the incident and consider it in his future practice.

Housing

Upheld

Vale of Glamorgan County Council – Housing

Case number 201606493 – Report issued in August 2018

Mr Y complained that the Vale of Glamorgan County Council (“the Council”) had failed, either in a timely fashion or at all, to complete the previously agreed schedule of rectification work to his property. Mr Y also complained that construction work to the main roof and annex roof of his property had been undertaken without appropriate Building Regulations approval.

The Ombudsman found that there were some avoidable delays on the Council’s part, although the majority of the delays Mr Y experienced were due to a combination of factors, including complex access negotiations with neighbours and a tendering process. The Ombudsman found that the Council had reasonably exercised its professional judgement in relation to the issue of Building Regulations issues and the Ombudsman could not intervene.

The Ombudsman recommended that the Council apologise to Mr Y for the avoidable delays.

Flintshire County Council – Group or block repair/ improvement grants (not DFGs)

Case number 201704323 – Report issued in September 2018

Mr S complained about Flintshire County Council’s (“the Council”) management and monitoring of works to install an external wall insulation (“EWI”) system at his home. He was concerned that the identified faults with the installation had not all been put right. Mr S also complained about the way the Council dealt with his concerns about the issue.

It was concerning that, over two years after the EWI system had originally been installed, some issues remained outstanding at Mr S’ home. The Ombudsman found that there had been some failings in the monitoring of the initial works and that some (but not all) of the subsequent delays were due to the Council. To that extent he upheld that part of the complaint. The Ombudsman found that for the most part the Council had responded to Mr S’ concerns in a timely manner; however, there was a delay in responding to some questions he had put to it. To that extent he upheld that part of the complaint. The Ombudsman recommended that the Council apologise to Mr S, pay him £500 to reflect the time and trouble he had been put to, and take steps to resolve the outstanding works in a timely manner.

City and Council of Swansea – Neighbour disputes and anti-social behaviour

Case number 201704517 – Report issued in September 2018

Miss A complained that the City and County of Swansea Council (“the Council”) had not adequately investigated her complaints of anti-social behaviour (“ASB”) and had not taken into account its equality duties when considering her complaints. She also complained about the Council’s handling of her complaint.

The Ombudsman’s investigation concluded that the Council had responded to Miss A’s and her partner’s complaints of ASB and had acted appropriately within its ASB guidelines. There was also evidence that the Council had applied the correct approach when reaching its discretionary decision on the equality aspects of Miss A’s complaint. The Ombudsman did not uphold these parts of Miss A’s complaint.

The Ombudsman did uphold to a very limited extent the complaint handling aspect of Miss A's complaint, given that there was a delay in the Council undertaking action that it said it had taken in its initial complaint response to her. The Ombudsman therefore recommended that the Council apologise in writing to Miss A for this shortcoming.

Early Resolution or Voluntary Settlement

Pembrokeshire County Council – Repairs and Maintenance (inc. dampness/ improvements and alterations e.g. central heating or double glazing)

Case number 201800781 – Report issued in July 2018

Mrs A complained about Pembrokeshire County Council's ("the Council") failure to complete damp repair works to her property despite reporting the problems for over four years. She also raised concerns about repairs to fencing and water pressure. Having initially contacted the Council, the Ombudsman was provided with a definite timescale for completion of the works by the end of October 2018.

The Ombudsman was satisfied that this timescale was reasonable and that the Council had adequately explained why it had been unable to complete the works sooner. The Ombudsman was also satisfied that the Council had already acted to address the other repairs. However, he was concerned that no definite timescale had been provided to Mrs A when the extensive nature of the damp works which required completion was first identified in August 2017. Because of this, the Ombudsman contacted the Council who agreed to carry out the following in settlement of Mrs A's complaint:

- a) To write to Mrs A immediately with a definite timetable/schedule for completion of the damp works
- b) Within one month, to provide a written apology for the failure to confirm the timescale for the completion of the works when the issues were first identified
- c) Within one month, to offer a redress payment of £250 in recognition of the uncertainty caused to Mrs A due to the failure to provide a definite timescale and her time and trouble in pursuing her complaint.

Clwyd Alyn Housing Association Ltd – Other

Case number 201801046 – Report issued in July 2018

Ms A complained that the Clwyd Alyn Housing Association ("the Housing Association") failed to acknowledge her report that there was no Telecare equipment in her property and that it continued to charge her for the monitoring and maintenance of the service.

Although the Ombudsman declined to investigate Ms A's complaint, he recognised that the Housing Association had no record to confirm that Telecare equipment was available in the property at the beginning of Ms A's tenancy and it also failed to investigate when Ms A reported that she did not have the equipment. Because of this, he contacted the Housing Association and it agreed to do the following within one month:

- a) provide a full written apology to Ms A for poor administrative practice and for failing to investigate when she reported that she did not have Telecare equipment in her home.
- b) to provide Ms A with a redress payment of £250, in recognition of the failure to investigate and the uncertainty caused by lack of records.
- c) to review its process on assignment of a property, to ensure that all charged for services are available and in working order.

Coastal Housing Group Ltd – Housing

Case number 201802808 – Report issued in August 2018

Ms B complained that a Coastal Housing Group Ltd (“the Housing Association”) had failed to carry out repairs to her boiler and roof. Ms B had not fully exhausted the Housing Association’s complaints procedure as her complaints had been treated as service requests. The Housing Association confirmed that, on receipt of Ms B’s complaints, home visits were undertaken by its Housing and Maintenance Officers to “try and address” Ms B’s concerns.

Therefore, the Housing Association agreed to complete the following actions by 27 September 2018 in settlement of Ms B’s complaint:

- a) Apologise to Ms B that her complaints did not receive a formal written response
- b) Explain the reason/s why Ms B’s complaints did not receive a formal written response
- c) Provide a formal written response to Ms B at the final stage of its complaint’s procedure.

Wrexham County Borough Council – Housing

Case number 201707022 – Report issued in August 2018

Mrs B was employed by Wrexham County Borough Council (“the Council”) as a Warden in a sheltered housing complex and had tied accommodation at the premises for which she paid rent by way of deductions from her wages. The Council failed to deduct the correct amount causing significant rent arrears and Mrs B’s later application for Council housing was subjected to an exclusion period of six months because of the debt. Mrs B complained that the Council’s decision to apply an exclusion period was unfair given that it bore some responsibility for her arrears and that she had been repaying the debt. Mrs B also complained about the Council’s handling of complaint.

The Ombudsman found that, when taking the decision to exclude Mrs B, the Council failed to consider the full facts of her case and to follow Welsh Government guidance. Furthermore, Mrs B was not properly advised of the reasons for the decision, the grounds for a review of that decision, when the exclusion period came to an end and the requirement to reapply for housing at the end of the exclusion period. These failings not only undermined the soundness of the Council’s decision but also prejudiced Mrs B’s ability to challenge the decision and prevented her from reapplying as soon as she could. Finally, the Ombudsman found that the Council had failed to respond to Mrs B’s complaint.

The Council was able to assure the Ombudsman that Mrs B had not missed out on an allocation of housing because of these failings and agreed to take the following action in settlement of the complaint:

- a) To make a payment of £500 to Mrs B, in recognition of the uncertainty and distress caused by the poor handling of her housing application and the failure to respond to her complaint.
- b) To reinstate Mrs B’s place on the housing waiting list as if she been waiting from 12 September 2016, when she first applied and write to her to confirm when this has been done.
- c) To provide training to relevant staff on the statutory conditions which must be satisfied before an exclusion can apply and the proper recording of decisions.
- d) To carry out a review of its policy and procedures to ensure that they meet with the statutory requirements and good administrative practice.

North Wales Housing – Housing

Case number 201707922 – Report issued in August 2018

Ms A complained about a lack of effective action being taken by North Wales Housing (“the Housing Association”) to bring noise nuisance from her neighbour to an end. She said that the noise was causing her sleepless nights and impacting significantly on her quality of life.

The Ombudsman found no evidence of failure by the Housing Association to take appropriate and timely action in response to Ms A reports of noise nuisance. However, its communication with Ms A during the course of its investigations had been poor giving her the impression that it was doing little in response to her concerns and that the impact of the nuisance she was experiencing was not being taken seriously.

In recognition of this, the Housing Association agreed to:

- a) Apologise to Ms A for the communication failings in this case; and to
- b) make a payment of £250 to Ms A in recognition of the distress this had caused.

Powys County Council – Housing

Case number 201707713 – Report issued in August 2018

Mrs A complained to the Ombudsman that Powys County Council (“the Council”) had failed to investigate and remedy damp issues in her home in line with its repair obligations as a social housing landlord. Notably, Mrs A was unhappy that cavity wall insulation had not been removed.

The Council agreed to;

- a) Remove the cavity wall insulation
- b) Install external wall insulation and damp course
- c) Carry out appropriate re-plastering and decorating
- d) Provide Mrs A with redecoration vouchers for the bedroom
- e) Carry out appropriate works to make good after repairs are completed

The Ombudsman discontinued his investigation into the complaint.

Clwyd Alyn Housing Association Ltd – Housing

Case number 201801830 – Report issued in August 2018

Mr B complained that Clwyd Alyn Housing Association (“the Housing Association”) continued to charge him for a Telecare service after he had reported that it was not working. He complained that despite raising his concerns with the Housing Association, it failed to remove the arrears that had accrued on his account. Mr B was unhappy with the Housing Association’s complaints response, as he felt that it had not addressed all the issues that he had raised.

Although the Ombudsman declined to investigate Mr B’s complaint, he recognised that the Housing Association had failed to investigate when it was notified of the potentially faulty equipment or acknowledge in any of its complaints responses that Mr B had notified it of the issue. The Housing Association failed to ensure that the charged for service was operable for Mr B’s benefit and it continued to charge him until 2018, when the service was no longer compulsory.

As a result, the Ombudsman contacted the Housing Association and it agreed to do the following within one month:

- a) remove the Telecare service charge arrears on Mr B’s account and inform him of the action taken.

Trivallis – Repairs and maintenance (inc. dampness/ improvements and alterations e.g. central heating/ double glazing)

Case number 201801539 – Report issued in September 2018

Ms A complained that her property had not been re-wired which was causing electrical goods to fail. She also complained that floor tiles in her living room were cracked and lifting, and at the time the complaint was made, had not been repaired. Ms A also complained about various other repairs to her property and about communication issues with Trivallis.

Although the Ombudsman declined to investigate Ms A's complaint, he was concerned that there had been a delay in addressing some of the issues raised by Ms A.

Because of this he contacted Trivallis who agreed to do the following:

- a) To apologise to Ms A for the delay of seven days in replacing the living room floor tiles;
- b) To make a payment of £5 to Ms A for the inconvenience caused to her by this;
- c) To apologise to Ms A for failing to fit her new electrical consumer unit in a timely manner;
- d) To ensure that the electrical consumer unit was fitted and an up to date Electrical Installation Condition Report completed;
- e) To make a payment of £250 to Ms A for failing to ensure that her electrical supply was remedied within a reasonable timescale.

Cartrefi Cymunedol Gwynedd – Repairs and maintenance (inc. dampness/ improvements and alterations e.g. central heating/ double glazing)

Case number 201802078 – Report issued in September 2018

Ms B complained that Cartrefi Cymunedol Gwynedd had unreasonably decided that it would not allow her to install a multi-fuel burner at her home. Cartrefi Cymunedol Gwynedd's Heating Policy stated that it would not allow tenants of its properties to install multi-fuel burners unless they were considered to be in "Fuel Poverty".

Although the Ombudsman declined to investigate Ms B's complaint, he was concerned that Cartrefi Cymunedol Gwynedd had incorrectly completed their assessment tool to consider if Ms B was in Fuel Poverty.

Because of this he contacted Cartrefi Cymunedol Gwynedd who agreed to do the following:

- a) To re-assess whether Ms B and her family were in Fuel Poverty;
- b) To apologise to Ms B for the error in the original Fuel Poverty calculation, and to re-consider her application to install a multi-fuel burner and for any other relevant support, should she be deemed to be living in Fuel Poverty;
- c) To offer Ms B a payment of £125 for the time and trouble she had experienced in bringing her complaint to the Ombudsman;
- d) To amend its Heating Policy to include references both to Disability Living Allowance and Personal Independence Payments;
- e) To ensure that all calculations of Fuel Poverty completed since April 2016 had been completed correctly, and/or to rectify any cases where errors had occurred, if any.

Cartrefi Conwy – Right to buy

Case number 201802745 – Report issued in September 2018

Mr A (who was a tenant) complained that he had tried to complete the purchase of his property from Cartrefi Conwy and that they had delayed without signing the documents, and at the last minute, insisted Include a frustration clause in the transfer document. This, said Mr A, had caused inconvenience who, by that time, was in rent debts and Cartrefi Conwy was unable to complete the sale and was financially losing.

In assessing the complaint, the Ombudsman stated that the purchase was controlled by the Housing Act 1985 ("the Act") and Cartrefi Conwy neglected the content of the clause in the initial documents, although they were entitled to include it under the Act before the final date. In addition, Cartrefi Conwy was entitled to require the rent account to be clear as Mr A's legal obligations, as a tenant, continued until the transfer. However, it was agreed that Mr A was bothered by having to sign two documents, and his time, due to the stated negligence. Cartrefi Conwy agreed to the Ombudsman's suggestion for resolving the complaint, as below:

- a) Apologize to Mr A in writing, and offer him £ 50 for his trouble in terms of the time and inconvenience identified (in a month)
- b) Agree to proceed with the sale of the property, if Mr A still wished, on the same conditions (with a clear rent account) and complete the process by 31 December 2018.

Cardiff Council – Tenancy rights and conditions/ abandonment and evictions

Case number 201803185 – Report issued in September 2018

Ms X complained that when she took up tenancy of her new property, it transpired that there was a serious blockage of the kitchen sink which rendered it unusable. The tenancy commenced on 6 August 2018 yet despite raising the matter with Cardiff Council ("the Council"), the issue with the blockage was not resolved until 13 August. Ms X was happy with the work which was carried out.

However, because the blockage rendered the sink unusable, Ms X felt that the property did not meet the standards set out in the 'What to Expect in Your New Home' brochure she had been given by the Council, and therefore the property was not fit to let. Consequently, she raised this point with the Council and requested a reduction in rent to reflect the sub-standard condition of the property between 6 and 13 August. In its response, the Council failed to fully address this request which led Ms X to complain to this office.

The Ombudsman is of the view that an opportunity exists in this case for the Council to take certain action to settle the complaint, under section 3 of the Public Services Ombudsman (Wales) Act 2005, in relation to the fact that the Council failed to address the request for a reduction in rent which has resulted in Ms X having to come to the Ombudsman which might have been avoided had the Council responded to the complainant on this point. I would therefore like to propose the following as a way of resolution for Ms X's concerns and her complaint to this office:

- a) Consider Ms X's request for a reduction in rent and respond to her regarding this matter within four weeks (5 October 2018)

Planning and Building Control

Early Resolution and Voluntary Settlement

City and County of Swansea – Planning and Building Control

Case number 201801745 – Report issued in August 2018

Mr X complained that the City and County of Swansea (“the Council”) had failed to take enforcement action against a restaurant which had not installed a ramp as per its planning application and about the length of time the Council had taken to respond to his concerns.

Mr X made an enforcement enquiry to the Council in February 2018 and understood that a response would be provided within 12 weeks. Mr X subsequently complained and received a Stage 1 complaint response in June 2018.

The Council explained to Mr X that enforcement investigations can take longer than 12 weeks. It did not offer an apology for the time taken, nor did it provide information to Mr X on how to escalate his complaint.

The Council therefore agreed to complete the following actions:

- a) Apologise to Mr X for the length of time taken in investigating the enforcement enquiry
- b) Explain the reasons for the delay
- c) Provide information to Mr X on how to escalate his complaint to Stage 2 of its complaints procedure if he remained dissatisfied with its response.

The Council provided evidence that it had written to Mr X on 23 August 2018 and had complied with the actions outlined above.

Arthog Community Council – Planning and Building Control

Case number 201801524 – Report issued in August 2018

Ms A complained about the process followed by Arthog Community Council (“the Council”) when it considered an application to Modify the Definitive Map of Public Rights of Way in the area as part of a statutory consultation. In addition, Ms A complained about the way in which her complaints were considered by the Council.

The Ombudsman was satisfied that the Council had acted reasonably following receipt of the consultation exercise in arranging for it to be considered and discussed by its members at a public meeting in the absence of any prescribed guidance or procedures for the consultation.

The Ombudsman noted that Ms A’s complaints about the actions of the Council had not been handled appropriately. In that the Council did not have a formal complaints process in place, did not provide a full and detailed response within a reasonable timeframe or provide any review or escalation advice in line with principles of good administration and Welsh Government’s Model Complaints Process.

The Council agreed to the following proposals by the Ombudsman:

- a) Apologise that to the Complaint for the way in which her complaint was handled.
- b) Adopt a formal complaints procedure within two months.

Flintshire County Council – Tree management/ TPOs/ High Hedges

Case Number 201802271 - Report issued in September 2018.

Mrs X complained that Flintshire County Council ("the Council") had failed to undertake a site visit to inspect a tree near the road opposite her home, despite the Ombudsman having referred her complaint to the Council several months earlier.

The Council acknowledged that the matter had been overlooked and, following the Ombudsman's intervention, arranged for a site visit to be undertaken. In recognition of the administrative failings in not having arranged the site visit promptly, the Council agreed to:

- a) Apologise to Mrs X
- b) Pay Mrs X £100 in recognition of the additional time and trouble to which she had been put in pursuing the matter.

The Ombudsman considered this to be a reasonable resolution.

Roads and Transport

Early Resolution and Voluntary Settlement

Caerphilly County Borough Council – Roads and Transport
Case number 201802541 – Report issued in August 2018

Mrs X complained that Caerphilly County Borough Council (“the Council”) failed to take into account mitigating circumstances when she made an appeal to it against an Excess Charge Notice (“ECN”) for car parking.

Whilst the Ombudsman does not perform an appellate function in these matters, he can consider the process the Council followed in responding to Mrs X’s appeal (i.e. unnecessary delay in responding or failing to advise on any rights to appeal).

In making enquiries with the Council regarding its ECN appeals procedure, the Ombudsman was informed that the Council had an “internal procedure” to deal with appeals and that this was a three-stage process. The Council said that appellants were not normally made aware of the three-stage process and that the procedure was not currently a written policy. The Ombudsman considered this to be a service failure on the part of the Council.

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

Within twenty working days of the Ombudsman’s decision:

- a) Apologise to Mrs X for failing to inform her of her right to escalate her appeal to Stage 2 of its appeal procedure
- b) Offer Mrs X the opportunity to appeal at Stage 2
- c) Make a payment of £50 to Mrs X for the time and trouble in making her complaint to the Ombudsman, and in recognition of the failure outlined above.

Within two months of the Ombudsman’s decision:

- d) Review its appeal procedure, including the way in which appellants are made aware of their rights to escalate appeals, and the way in which the procedure is published
- e) Identify any other individuals – since 1 April 2018 – who have not been informed of their right to escalate their appeal and contact them to advise them of their right.

Caerphilly County Borough Council – Parking
Case number 201803391 – Report issued in September 2018

Mr X complained that Caerphilly County Borough Council (“the Council”) failed to take into account mitigating circumstances when he made an appeal to it against an Excess Charge Notice (“ECN”) for car parking.

Whilst the Ombudsman does not perform an appellate function in these matters, he can consider the process the Council followed in responding to Mr X’s appeal (i.e. unnecessary delay in responding or failing to advise on any rights to appeal).

The Council had an "internal procedure" to deal with ECN appeals, which has three stages, although appellants are not routinely made aware of this and there was no written policy. The Ombudsman considered this to be a service failure on the part of the Council.

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

Within twenty working days of the Ombudsman's decision:

- a) Apologise to Mr X for failing to inform him of his right to escalate to Stage 2 of its appeal procedure
- b) Offer Mr X the opportunity to appeal at Stage 2
- c) Make a payment of £50 to Mr X for the time and trouble in making his complaint to the Ombudsman, and in recognition of the failure outlined above.

Since, in relation to a similar complaint, the Council had already agreed to review its procedure and identify other individuals who had been similarly affected, the Ombudsman consider the agreed actions to be reasonable.

Social Services – Adult

Upheld

Newport City Council – Adult Social Services

Case number 201700724 – Report issued in August 2018

Ms C complained that from September 2013 her relative, Ms D, who has learning difficulties, was not provided with adequate care by Newport City Council (“the Council”) and it left her without support. In particular, it did not assess her capacity to oversee her financial affairs or arrange for an appointee to do so.

The Ombudsman found that a formal capacity assessment was not carried out by the Council for a period of almost four years, despite it identifying on five separate occasions that Ms D was vulnerable and did not understand basic money calculations. The Council left Ms D to handle her own financial affairs and at risk of exploitation. Further to this, the Ombudsman found that when the Council was made aware of Ms D being potentially exploited financially, it did not make a safeguarding referral or investigate the concerns that had been raised seriously enough. However, the Ombudsman found that overall the general support offered to Ms D by the Council was reasonable.

The Ombudsman said that Ms D should have been safeguarded financially by the Council and it was a significant injustice that she was not. The Council accepted the findings in the report and acknowledged its role in the failings of the case.

The Council agreed to take the following actions:

Within one month:

- a) Write appropriate letters of apology for the failings identified in this report.
- b) Make a payment to Ms D of an agreed amount for the identified failing of not adequately assessing her need for financial safeguards between September 2013 and April 2017.
- c) Make a payment of £500 to Ms C in recognition of the distress caused by its failure as outlined in (b) and ignoring her correspondence.

Within three months:

- d) Ensure that arrangements are in place, so consideration is given to financial management during its annual review of cases and determine how it will review concerns it receives in relation to financial issues and capacity.
- e) Discuss the contents of this report with the Community Adult Learning Disability Team to identify learning areas.
- f) Ensure arrangements are in place so relevant staff are reminded of the need to take accurate notes and evidence the rationale for decisions in relation to capacity.

a) Within six months:

- g) Demonstrate that all relevant Social Workers have either recently undergone or will undergo refresher training in relation to the Mental Capacity Act and how to undertake and record capacity assessments.

Flintshire County Council – Regulation and Inspection (including private sector provision)

Case number 201604471 – Report issued in September 2018

Ms A, who was a joint owner with her husband of a domiciliary care company, complained about a number of issues including Flintshire County Council's ("the Council") failure to make reasonable adjustments for her disability (dyslexia).

Based on the facts of the case, the Ombudsman upheld to a limited extent only three parts of Ms A's complaint. He felt that there had been a failure by officers to consider the need for reasonable adjustment at a meeting that Ms A attended with her husband. He also felt that officers at the meeting had not taken into account its policy on ensuring the Council's services are accessible.

Additionally, given Ms A's reading impairment, the Ombudsman concluded that providing Ms A with a written list at an inspection visit was not sufficient reasonable adjustment and did not accord sufficiently with the Council's policies around diversity, equality and accessibility.

He also upheld aspects of Ms A's complaint relating to complaint handling.

The Ombudsman's recommendations to the Council included the following. The Council should write to Ms A and acknowledge her distress and set out the points of learning it would implement. In addition, it was asked to consider refresher training around the equality legislation and in particular reasonable adjustments.

Welsh Government – Care Inspectorate Wales – Regulation and Inspection (including private sector provision)

Case number 201604474 – Report issued in September 2018

Ms A, who was a joint owner with her husband of a domiciliary care company, complained about a number of issues including Care Inspectorate Wales' ("CIW") failure to make reasonable adjustments for her disability (dyslexia).

Based on the facts of the case, the Ombudsman upheld to a limited extent only three parts of Ms A's complaint. The Ombudsman concluded that at an inspection visit there was no evidence that reasonable adjustments had been considered by CIW. This led to failings in other areas including complaint handling.

The Ombudsman recommended that CIW apologise to Ms A for the failings identified and consider refresher training around the equality legislation and in particular reasonable adjustments.

Early Resolution and Voluntary Settlement

Rhondda Cynon Taf County Borough Council – Adult Social Services

Case number 201801638 – Report issued in August 2018

Mrs B complained that Rhondda Cynon Taf County Borough Council ("the Council") had failed to fulfil its caring responsibilities to her husband who was terminally ill with cancer. Mrs B said that the Council did not return her calls regarding home care support and advised her to leave her husband in a chair overnight.

Although the Ombudsman declined to investigate Mrs B's complaint, he was concerned that the Council had refused to investigate Mrs B's complaint under Stage 2 of its own Complaints Procedure.

Because of this he contacted the Council who agreed to investigate Mrs B's complaint in line with Stage 2 of its Complaints Procedure.

Powys County Council – Adult Social Services

Case number 201801900 – Report issued in August 2018

Mr X raised a number of concerns about the care provided to his late father by Powys County Council's ("the Council") Care Team. His concerns included the Council changing the times of the morning assistance which affected his father's daily routines, such as the time he could get out of bed, shower, and have his morning medication.

The Council advised the Ombudsman that, following the death of Mr X's father, it decided it would be insensitive and callous to write to the family and therefore decided not to commence an investigation.

The Ombudsman expressed his concerns to the Council that the family was not given the opportunity to receive answers to their complaint and that it had been one year since the complaint was initially raised.

The Council apologised for its failure in the complaint handling and agreed with the Ombudsman to contact Mr X. It has arranged a meeting to discuss the best way forward. The Council also agreed to pay Mr X £250 in recognition of the complaint handling failing.

Social Services – Children

Not Upheld

Conwy County Borough Council – Children's Social Services
Case number 201701053 – Report issued in August 2018

Mr X and Ms Y complained about their unclear role and status in respect of a mother (Ms A) and her young child who had moved to live with them at their home after safeguarding concerns had arisen about the child. Mr X and Ms Y stated that they had signed an agreement at their home for the child to be placed in their care under their guardianship. They were aggrieved that a copy of the agreement was not provided to them. They complained about the way Conwy County Borough Council ("the Council") had subsequently dealt with Ms A and the child's residential arrangements. The complainants were concerned that they had fallen into debt because of the unsatisfactory arrangement that was put into place by the Council. Finally, they were aggrieved with how the Council had responded to the independent investigation of their complaints about this matter.

The agreement was unavailable for consideration, so its content was uncertain. The investigation found that Ms A and child's move to the complainants' property was likely to have been a voluntary informal arrangement rather than a formal placement. Mr X and Ms Y could not have been made special guardians by any one document signed at their home; an application to court would have been required and a court order subsequently made. The child could not have been formally placed with Mr X and Ms Y as they had never been "looked after" by the Council. There was no indication in the Council's records that it intended for anyone other than Ms A to care for the child. The independent investigation of this complaint was found to have been significantly flawed so the Council's response to it had not been unreasonable. Nevertheless, the Council had offered a payment of £2080 to the complainants as a result of that investigation, which the complainants declined. The Council was found not to have dealt with this matter unreasonably, so the complaints were not upheld.

Various Other

Upheld

Ceredigion County Council – Various Other

Case number 201703228 – Report issued in August 2018

Mr A complained that Ceredigion County Council (“the Council”) had acted wrongly in its dealings with land and school buildings within its area (“the School”). He said that when the School closed in August 2014, the land should have reverted to his ownership under the terms of a deed entered into by his ancestors in 1859. This deed contained a “reverter clause” - then common where land was bestowed by an owner for charitable purposes including the setting up of rural schools. Mr A also complained about the Council’s handling of his subsequent complaint after he had repeatedly told it of his claims – both before and after the School closed. In addition, Mr A complained about the actions of the St David’s Diocesan Board of Finance (“the Board”). The Council had later (in 2015) transferred the land to the Board who claimed ownership of it on behalf of the Church (given the original deed had expressed that the School’s teaching should be compatible with that of the Church). Mr A had been pursuing his grievances with both the Council and the Board since.

The investigation found that the Council had failed to properly investigate or consider Mr A’s position (despite a public declaration to do so during the consultation on the School’s proposed closure). It further had failed to keep any proper records of any steps taken to verify ownership, or of the Board’s claim, and had simply transferred the land to it. The Council had also not properly dealt with Mr A’s subsequent complaint, simply referring him to the Board.

Whilst the Ombudsman had no jurisdiction over the Board, he commented that the investigation revealed it was not beyond reproach for its role in events. It had contributed to Mr A’s injustice and his having to expend sums in legal costs to try to argue his legitimate claim (as verified by the Counsel’s opinion sought). The Ombudsman was unable to make recommendations to the Board but felt it should reflect on its position.

Early Resolution or Voluntary Settlement

Student Loans Company – Poor/No communication or failure to provide information

Case number 201800857 – Report issued in July 2018

Mr H complained that the application process for additional funding, on the grounds of Compelling Personal Reasons, was lengthy, complicated and confusing and that he waited weeks for a response to his complaint, which left many of his questions unanswered. Then, after being advised that he would receive funding for the academic year 2018/19, Mr H was told on the ‘phone that his tuition fees would not be paid after all.

The Ombudsman considered that Mr H’s complaint was dealt with in a reasonably timely manner, notwithstanding that the amount of correspondence exchanged before it was appropriately escalated to Stage 2 may have contributed to Mr H’s perception that he was being “stonewalled”. He also noted that the Student Loans Company (“SLC”) should have recognised and used Mr H’s preferred method of communication. The SLC had already fed back to relevant staff members on those points, although Mr H had not fully exhausted the complaints procedure through Stage 3.

Additionally, the Ombudsman found that Mr H was given misinformation during a telephone conversation that had led him to believe he had not been awarded funding for the academic year 2018/19 when, in fact, funding had been awarded. It was agreed that the SLC would:

- a) Apologise for the apparent confusion during the telephone call on 12 April 2018
- b) Offer to deal with any outstanding concerns at Stage 3 with a relevant referral date of the 14 May (i.e. the date Mr H contacted the Ombudsman)

[Velindre University NHS Trust – Various Other
Case number 201801587 – Report issued in August 2018](#)

Mrs A complained about the care and treatment provided to her late husband by Velindre University NHS Trust ("the Trust") in July and October 2017. She said clinician appointments were rushed and lacked empathy, and a member of staff was cold, abrupt and discourteous. Mrs A said the Trust's complaint response failed to adequately address her concerns or acknowledge the issues she raised.

Although the Ombudsman declined to investigate Mrs A's complaint, he recognised the Trust's complaint response was reasonable and appropriate. However, it appeared not all Mrs A's specific concerns about staff attitude had been addressed adequately. Due to this, the Ombudsman contacted the Trust and it agreed to do the following within one month of the date of this decision.

- a) Arrange to meet with Mrs A to discuss her concerns about the care and treatment her late husband received, and to explain any steps being taken to prevent future occurrence.