The Ombudsman's Casebook

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Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

A word from the Ombudsman

Once again, this issue of the Ombudsman's Casebook is a bumper edition, evidencing the volume of complaints that are made to my office on a daily basis. As in the last edition, the majority of the complaints reported in this Casebook deal with health-related issues, reflecting the fact that the number of complaints about aspects of the health service continues to rise. Indeed, there has been an increase of 11% in health-related complaints during 2013/2014 compared with those received in 2012/2013. The reasons behind this increase may be both many and varied including, inter alia, greater expectations of the NHS, a larger number of procedures giving rise to a greater scope for things to go wrong and an increased willingness for people to complain as well as poor complaint handing and the obvious explanation that the quality of health service provision sometimes falls short of where it should be.

Of particular interest in this collection of case summaries is the inclusion of several complaints against General Practitioners, some of which are referred to in the Lessons Learnt section of this edition. It is very easy to think of health-service complaints as relating to hospital care while losing track of the fact that all primary healthcare providers such as General Practitioners, Dentists and Opticians fall within the ambit of the Ombudsman's jurisdiction as well.

(Continued overleaf)

As always, there are certain themes that come out of the case reports and which, though evident in health-service complaints, are not restricted thereto but can equally be found in complaints about local authorities and housing associations. In addition to the issues about record keeping, to which I referred in the last issue, clear themes are evident particularly around delays in processes, be they health service or local authority, keeping complainants informed about the progress of their complaint and a failure to tell complainants how to escalate their complaint to the Ombudsman. In so many ways, communication can be key and even delays in process may be more acceptable if the complainant is informed about the reason for the delay, assuming that it is both justifiable and does not endanger anybody.

Given the old adage that 'justice delayed is justice denied', it is pleasing to note the number of 'quick fixes' which result in a swift, and satisfactory, outcome to the complaint with the appropriate action/remedy taking place quickly instead of being the subject of a longer, formal investigation. Many of these 'quick fixes' relate to housing issues, particularly repair and maintenance, in which it was possible to negotiate for the necessary work to be completed within a reasonable period. Quick fixes can also be helpful in respect of complaints concerning financial matters such as Council Tax Benefits and Housing Benefit while also being very useful in addressing disputes relating to the payment of the costs of Continuing Health Care.

Professor Margaret Griffiths
Acting Ombudsman

Lessons Learnt

GPs

This issue of The Ombudsman's Casebook covers the final quarter of 2013/14 and includes a number of cases relating to GPs. The continuing rise of health complaints is often noted by this office and, whilst many of those complaints relate to 'clinical treatment in hospital', there are also a significant number which can be best categorised as relating to 'clinical treatment outside hospital'. Generally, complaints concerning GPs will fall into this latter group.

A glance through previous Annual Reports confirms that the general rise in health complaints has incorporated a rise in complaints about GPs. In 2012/13, this office recorded 91 outcomes against GPs, compared to 36 in 2008/09. The figures for 2013/14, which will be included in the Annual Report to be laid before the National Assembly for Wales, indicate a similar number of outcomes to last year. However, whilst there has been an increase in the number of complaints, the figures for those cases taken into investigation over the last five years do not suggest an overwhelming predominance of either upheld or not upheld complaints.

However, in reference to the last quarter of 2013/14, there have been a number of reports issued against GPs which should be noted. The complaints which gave rise to these reports have concerned such matters as shortcomings in respect of clinical examinations and assessments, complaint-handling, prescribing errors and record-keeping.

In one case (201302226), the Ombudsman received a complaint regarding the clinical assessment, diagnosis and treatment of a young patient. Two days after a GP's diagnosis of Obstructive Sleep Apnoea, the patient was admitted to hospital and had an emergency operation following the GP's failure to diagnose acute tonsillitis. The Ombudsman concluded that "the severity of the symptoms and sudden deterioriation should have led the GP to seek a paediatric opinion on that very same day", rather than making a routine referral. Finally, the adviser noted that the GP failed to pick up on the patient's enlarged tonsils and did not record any findings of a throat examination. The Ombudsman recommended that the GP should apologise, make a redress payment in recognition of the uncertainty and distress caused to the family, discuss the case at their next appraisal, and reflect the matter in the GP's next personal development plan.

In another case (201203584), the Ombudsman received a complaint that a patient had been prescribed the wrong dose of a particular drug. The patient suffered a reaction which required hospital treatment. Whilst noting shortcomings by a Pharmacy and the Health Board, the report noted that the responsibility for prescribing the correct dose rested with the GP. The report concluded that the GP had failed to check a number of easily accessible sources to confirm the correct dose of the drug. The report also noted that the GP had failed to review the dose he had previous prescribed when the patient later presented with symptoms suggestive of a reaction to the drug, despite the fact that the GP had suspected a reaction to the drug. In this case, the

Ombudsman also recommended that the GP should apologise and make a redress payment. Finally, it was also noted that paediatric neurology advice suggested that there are no detrimental long-term effects for the patient from the overdose.

It is important to note that not all reports issued against GPs were upheld, and there were instances whereby the Ombudsman had concluded that the assessment or treatment provided to a patient by the GP in question had been acceptable based on the clinical presentation at the time (201300501 and 201301483, although the latter noted shortcomings in a consultation provided by a Nurse practitioner). As with other types of complaints to this office, there were also a number of examples whereby a GP had failed to provide an adequate response to a complainant, or had not actually been given an opportunity to respond.

The Ombudsman's Factsheet on General Practitioners sets out that this office will assess whether the standard of care was reasonable in the circumstances at the time, as reflected in those complaints which were not upheld. Nevertheless, as the first port of call in respect of health issues or concerns, GPs must ensure that they provide an acceptable standard of care and assessment. As with all other service providers, GPs should also record their actions and be able to support their actions in the event that the matter requires investigation by this office. Important lessons can and should be learnt from the above cases, which show the potential consequences where the standard of care is not reasonable.

Key Questions

Is the clinical examination/assessment reasonable?

Would I be satisfied with the clinical examination/assessment which has been performed?

Have the findings of the examination/assessment been recorded fully and accurately?

Are all materials for prescribing, and any guidance which may be required by a GP, easily accessible?

Case Summaries

Health

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

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204130 – Report issued February 2014
Mrs T complained about the treatment her husband, Mr T, received in hospital. She complained that he received excess intravenous fluids and that this fluid overload caused subsequent health problems, including multiple strokes, from which he sadly died in May 2011. Mrs T also complained that errors were made in her husband's medication when admitted to hospital, that the diagnosis of his stroke was delayed and that had he received appropriate and timelier treatment, he may have survived.

The Ombudsman found that the instance of fluid overload was not clinically significant in terms of the sad outcome. However, the Ombudsman upheld Mrs T's complaint, finding that the Health Board had failed to act in accordance with national guidelines for the treatment of stroke. The Ombudsman concluded that errors were made with Mr T's regular medication and that opportunities to diagnose Mr T's stroke and to implement treatment which may have increased his chances of survival were missed.

The Ombudsman recommended that the Health Board should:

1. Issue to Mrs T and her family a comprehensive apology for the failings identified in this report.

2. Review its arrangements in respect of post-admission medication reconciliation and ensure that a systematic medicine reconciliation programme is in place.

3. Ensure that staff training in respect of recognising acute stroke is up to date, with particular reference to the 2012 Stroke Guidelines issued by the Royal College of Physicians.

4. Ensure that use of the Rosier score system (or a similarly recognised tool), in order to identify patients who are likely to have had an acute stroke, is implemented.

5. With particular reference to the current Stroke Guidelines and NICE guidance, review its arrangements for the identification and treatment of acute stroke and consider including the following measures:

a) All patients who may have had an acute stroke (i.e. have been assessed as having a positive Rosier score) should be immediately assessed by a physician trained in stroke medicine to determine whether thrombolysis is suitable;

b) Suitable patients should have immediate CT scanning and, in all cases, within one hour;

c) All patients who may have had an acute stroke should be admitted immediately to a specialist acute stroke unit;

d) All patients who may have had an acute stroke should have a swallowing screening test, using a validated tool, by a trained professional within four hours.

6. Review the findings set out in its various complaint responses to Mrs T and to this office and take action to ensure that its own complaints investigations are in accordance with the Putting Things Right scheme, are sufficiently robust, demonstrably independent and, where appropriate, critical of identifiably poor care, which should include the introduction of a quality assurance audit of a sample of its completed complaint investigations.

7. Issue to Mrs T a cheque in the sum of £5000 in respect of the time and trouble to which she has been put in pursuing this complaint and in recognition of the additional distress caused to her and her family as a result of the uncertainty with which they now live over whether Mr T might have survived the initial stroke.

Other reports - Upheld

Cardiff and Vale University Health Board & Spire Cardiff Hospital – Clinical treatment in hospital
Case references 201300351 (Upheld) & 201301427 (Not Upheld) – Report issued March 2014

Mrs A complained about her surgical care and management by a Health Board Consultant for a gynaecological procedure. Mrs A had been advised she needed a specific procedure to deal with her condition. Following a number of cancellations, Mrs A's surgery was performed by the Health Board's Consultant at a private hospital in March 2008 under the then "second offer scheme" – a Welsh Government waiting list initiative whereby a patient who had planned surgery cancelled at least twice might have the procedure performed at a private hospital, but paid for by the NHS. In particular, her complaints centred on the following: the Consultant performed a different (lesser) surgical procedure on the day; and, she later suffered problems and required the original planned procedure in any event in 2012. Mrs A complained that she had eventually undergone three surgeries to deal with her problems which she felt would not have been necessary had the original planned procedure been performed. Alternatively, Mrs A said the Consultant had done something wrong. She maintained a loss of income throughout this time and said her relationship had broken down as a consequence of events. Mrs A also had concerns about the time taken by the Health Board to deal with her complaints.

In conjunction with the Ombudsman's independent clinical adviser ("the Adviser") records were examined and flaws in the consenting process and documentation highlighted. Mrs A had not been properly consented for the procedure actually performed and there was no evidence that she had been appraised of any alternative procedure which might be performed in theatre that day. However, there was no evidence to suggest that what was performed was not what the situation warranted. The Adviser commented that, for internal gynaecological conditions, a surgeon in a theatre setting is often able to "have a better look" at the patient than in an outpatient's clinic. Whilst the consent was specific to a different procedure it was likely the decision to proceed was taken with the best of intentions in that context; exposing Mrs A to a lesser surgical procedure. She had been content immediately afterwards. There was no evidence to suggest that anything untoward happened in theatre. The condition Mrs A suffered from often involved a need for further surgery, including when the more invasive operation was carried out. There was no 100% guarantee there would be no future problems. Whilst raising concerns about the consenting process and documents with the Health Board, the Ombudsman did not uphold the clinical complaint against either the Health Board or the private hospital.

There had been a significant delay in the Health Board's handling of Mrs A's complaint, taking a year to provide a response. This complaint was upheld. The Ombudsman's recommendations, as follows, were accepted by the Health Board:

a) a written apology to Mrs A for its complaint handling failure;
b) redress for the time spent in pursuing that complaint of £500.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204753 – Report issued March 2014

Mr A complained to the Ombudsman about the care and treatment that he received in 2009 when he attended the Emergency Unit (A&E) at the University Hospital of Wales with a wrist injury.

Mr A complained that although an X-ray confirmed he had fractured his wrist and that the damaged bone was displaced, A&E clinicians made no initial attempt to manipulate the fracture. He complained that a delay in doing so impaired his recovery and that the manipulation that was subsequently conducted set his wrist "incorrectly".

The Ombudsman did not uphold Mr A's complaint that the delay adversely impacted on his recovery, but did uphold Mr A's complaint that the manipulation resulted in the fracture healing with a degree of malunion. The Ombudsman recommended that:

a) the Health Board apologise to Mr A for a failure to identify malunion as the cause of pain and restricted movement, and for failing to take appropriate clinical measures to correct this;
b) the Health Board pay Mr A £300 in recognition of the time and trouble involved in arranging and attending additional hospital appointments and in pursuing his complaint;
c) Health Board clinicians offer to conduct a full clinical assessment of his wrist. Having done this, the Health Board should offer Mr A an appropriate payment for any loss of function;

d) following this assessment, clinicians should meet with Mr A to discuss potential further clinical interventions;
e) the Health Board reminds relevant clinicians of the importance of obtaining serial radiographs in patients who have sustained fractures until such time as the fracture has been demonstrated to have united on x-ray, particularly in the situation in which the patient is not improving as one would expect.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201204594 – Report issued March 2014
Mr X complained about the care and treatment his late brother, Mr Y, received whilst he was a patient at Singleton Hospital between 21 September and 28 October 2012.

The Ombudsman found that the failure to adequately monitor Mr Y had resulted in him dehydrating which contributed to the severity of Mr Y's renal failure. The Ombudsman also found that the medical records failed to fully reflect Mr Y's condition, and as a result opportunities to identify Mr Y's deterioration were missed.

The Ombudsman found that the care and service received by Mr Y had been affected by the lack of weekend doctor reviews and the paucity of senior medical staff on the Ward. The Ombudsman also found that the nursing staff had failed to keep Mr Y warm and comfortable whilst he was a patient on the Ward.

The Ombudsman recommended that the Health Board:

a) provide Mr X with a letter of apology from the Chief Executive for the failings identified in this report;
b) pay Mr X the sum of £250 in recognition of the time and trouble in bringing his complaint to the Ombudsman;
c) pay Mr Y's family the sum of £500 in recognition of the failings identified in the report;
d) remind the relevant staff of the importance of good record keeping;
e) remind the relevant clinicians of the importance of fully documenting assessments and reviews in the medical records;
f) remind all staff of the need to ensure that patient's fluid levels are adequately monitored;
g) provide refresher training for the relevant staff on dehydration and when to initiate fluid monitoring;
h) ensure adequate blankets are available to all patients within the First Hospital;
i) consider how Consultant care is impaired by the current weekend working arrangements, and provide evidence of what consideration has been given to resolve the matter.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204924 – Report issued March 2014
Mr M complained about the lack of Deep Vein Thrombosis (DVT – a blood clot that develops in the vein) risk assessments undertaken and venous thromboembolism (VTE) prophylaxis treatment (a preventative treatment for blood clotting) provided to his late wife, Mrs M, during her admission

to a community hospital within the local area of Cardiff and Vale University Health Board. Mr M said that DVT prevention was not discussed with the family and he complained about the various explanations that had been provided by the Health Board in response to his concerns.

Having obtained professional advice on the clinical aspects of Mrs M's care, the Ombudsman upheld the complaint. The Ombudsman found that the relevant NICE Clinical Guidance had not been applied. Therefore, an appropriate and formal risk assessment tool for DVT was not in place at the time of Mrs M's admission. There was also no supporting documentary evidence that DVT risk assessments were undertaken or to confirm that this was discussed with the family. The Ombudsman found that prophylaxis should have been provided to Mrs M and the Health Board had not satisfactorily explained why this did not happen. Whilst an opportunity was missed to minimise Mrs M's risk of developing a DVT, the Ombudsman was unable to conclude that if prophylaxis had been provided this would have altered the sad outcome. Finally, the Ombudsman found that much of what the family had to say during the complaints process was supported by the professional advice that she had received and this had not been acknowledged by the Health Board.

The Ombudsman recommended the following:

- an apology for the failings identified;
- a payment of £3,000 in recognition of additional distress due to the uncertainty caused to the family;
- that admission clerking proforma and medication charts include a formal DVT risk assessment tool;
- that regular audits should be carried out in relation to DVT prevention;
- that the Health Board should reflect on its complaints handling to ensure that it is sufficiently robust and independent;
- that the Health Board should remind staff of the importance of good record keeping;
- that the Health Board should consider the report as part of the Consultant Physician's next appraisal.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204684 – March 2014

Mr Y complained about the care and treatment that his late wife received at Ysbyty Gwynedd. He was of the view that Mrs Y was given excessive oxygen at the Emergency Department in 2011 which led to Mrs Y requiring intensive care and ventilation. Mr Y also said that whilst Mrs Y was in the Intensive Care Unit there was a failure to adequately monitor the antibiotic gentamicin which subsequently led to Mrs Y suffering with renal failure. Finally Mr Y expressed concern about the Health Board's complaint responses.

In reaching her conclusions the Ombudsman took into account the clinical advice provided by four of her professional advisers.

The Ombudsman found that there was no evidence that Mrs Y received the necessary blood gas testing in the Emergency Department. She concluded that this shortcoming probably led to Mrs Y receiving an inappropriate volume of oxygen and likely caused her to need slightly earlier ventilation than would otherwise have been the case. She was of the view however that this intervention would have been required at some stage due to the underlying nature of Mrs Y's condition. The Ombudsman was concerned that the incident must have been distressing to Mr and Mrs Y and highlighted that with better management there might have been a little more time to adjust to the circumstances they were almost inevitably facing. To that extent the Ombudsman upheld this element of the complaint.

In relation to the monitoring of the antibiotic, the Ombudsman found that although this medication may have played a part in Mrs Y's deterioration that there was nothing to suggest that the actions taken by the clinicians had been unsatisfactory. She noted that on the whole this medication was reasonably managed and that Mrs Y's kidney function had been adequately considered. The Ombudsman did not uphold this element of the complaint.

The Ombudsman partially upheld the complaint about the Health Board's complaint response. She concluded that although the responses were not wholly unreasonable, it was a shortcoming that the problem with blood gas testing had not been highlighted. She was also of the view that a meeting should have been arranged in line with the 'Putting Things Right' framework.

The Health Board agreed to implement the following recommendations:

1. apologise to Mr Y for the shortcomings in the care provided to Mrs Y during the period she was treated at the Emergency Department and for the limitations in its complaint response;

2. provide financial redress of £400 to Mr Y in light of the shortcomings;

3. introduce additional guidance to medical staff to increase their awareness of national guidelines along with the specific need for arterial blood gas analysis in patients with respiratory disease presenting as an emergency with shortness of breath.

GP in Cardiff and Vale University Health Board area – Clinical treatment outside hospital
Case reference 201302226 – Report issued March 2014
Mr and Mrs N complained about the shortcomings in the GP's clinical examination/assessment, diagnosis and treatment planning in respect of their young daughter (Miss N) on 17 August 2012.

The GP examined Miss N and reviewed a film recording showing the child struggling to breathe. The GP diagnosed Obstructive Sleep Apnoea (OSA) and Mrs N said that she was advised that there might be a wait for further investigation by ENT.

Two days later Miss N was admitted to hospital and had an emergency operation to open up her airways (removal of her tonsils and adenoids). She spent a number of days in intensive care. Acute tonsillitis causing airway obstruction had failed to be identified earlier by the GP.

Mrs N also raised concern about the GP's subsequent complaint response to her.

The Ombudsman took advice from one of her clinical advisers, an experienced GP. She concluded that a routine referral for a paediatric opinion was an unsatisfactory response in Miss N's case. The Ombudsman noted that this was a very uncommon presentation which would be outside the usual scope of a GP's day to day practice.

Taking account of the clinical advice, the Ombudsman concluded that the severity of the symptoms (including excessive sleepiness) and sudden deterioration should have led the GP to seek a paediatric opinion on that very same day. She found that it was also likely that the GP failed to pick up on Miss N's enlarged tonsils and did not record any findings of a throat examination. The Ombudsman was of the view that this was unsatisfactory. It seems likely that had Miss N been admitted to hospital on 17 August a more planned response could have been provided and the emergency situation could have been avoided.

The Ombudsman was of the view that there was service failure in this case. She also said that the complaint response provided by the GP was inadequate, particularly as it failed to fully identify the shortcomings. The Ombudsman upheld the complaint. In view of the injustice suffered by Miss N and her family, the Ombudsman recommended that the GP should:

a) apologise to Mr and Mrs N for the shortcomings in the care and treatment provided and offer financial redress of £1,150 to go some way towards recognising the uncertainty and distress that was caused for Miss N and the family;
b) discuss this case at the GP's next NHS appraisal and ensure that the management of respiratory disease in children is reflected in the GP's next Personal Development Plan.

The GP subsequently agreed to implement the Ombudsman's recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204283 – Report issued March 2014
Mr S complained about his management and care following his emergency admission to hospital with suspected appendicitis. In particular, his complaints centred on the following: a delay in being seen by a doctor at the ED; a delay in being administered pain relief, both at the ED and later the following morning on a ward, a lack of monitoring; a delay in being seen by a Consultant and in being taken to theatre for surgery by which time his appendix had perforated. He also had concerns about the handover process when a patient moves wards.

The investigation found a number of failings in Mr S's care. In relation to the ED, the complainant had not been given adequate pain relief promptly as befitted his level of recorded pain. The nursing records were minimal so not providing sufficient evidence of care provided there. Handover communication as not properly evidenced. On the ward overnight, and until Mr S was taken to theatre at lunchtime, inadequate observations and monitoring were performed and recorded. When pain relief was administered it was in oral form even though Mr S was due for theatre when a slot became free. So the majority of Mr S's complaints were upheld. The decision not to take Mr S for surgery overnight was in line with national guidance (not being life threatening) and so within the bounds of acceptable clinical practice. Whilst the appendix had perforated histology revealed it to be minimal, with no risk of peritonitis resulting. This aspect of the complaint was not upheld.

A number of recommendations were made, all of which the Health Board agreed to implement:

a) an apology to Mr S and redress of £750 for the failings found;
b) a review of the ED arrangements for analgesia and of handover processes – copies of new protocol documents to be provided to the Ombudsman in both instances;
c) a governance review within 3 months of nursing professional standards covering assessments, physiological and pain monitoring, record keeping and onward transmission documents between the ED and other clinical environments. Evidence of that review should be provided to the Ombudsman within 2 months thereafter.

GP in Hywel Dda Health Board area & Hywel Dda Health Board – Other
Case references 201204580 & 201301744 – Reports issued March 2014
Mrs P complained to the Ombudsman about Hywel Dda Local Health Board ("the Health Board"), a GP Practice ("the Practice"), a GP in the Health Board's area ("the GP") and also about the out of hours service ("the OHS") provided by the Health Board. She said that she was concerned about aspects of the care provided to her husband ("Mr P") from November 2010 until he died in January 2011. Mrs P said that the Independent Complaints Secretariat ("the ICS") had issued a report following an independent review, but she remained unhappy that her concerns had not been properly addressed by the Practice or the Health Board.

The investigation into the complaint against the Practice found evidence to support Mrs P's complaints that the GP did not make a note of his house call on 29 November 2010. The investigation also found shortcomings in the way in which the Practice dealt with Mrs P's complaint, the complaint records that it kept, and the way in which it engaged with the complaint process.

The investigation did not find evidence to support Mrs P's complaints that blood tests were not undertaken and that the results of blood tests had not been considered by the practice; that she was advised to personally arrange a blood transfusion; or that there was a lack of monitoring and intervention between Mr P's discharge from the First Hospital and admission to a private hospital. There was also no evidence that the Practice failed to monitor and assess Mr P following his discharge from the private hospital, and that blood tests (Mrs P said were requested by a private hospital) were not arranged by the Practice.

The investigation into the complaint against the Health Board found evidence of shortcomings:

- in the decision to discharge Mr P on 25 November 2010;
- the inadequate information about his warfarin regime, which included in the handwritten discharge summary;
- the standard of record-keeping; and,
- the Health Board's handling of Mrs P's complaint.

The investigation did not find evidence of service failure or injustice in relation to the decision to carry out a physiotherapy stair assessment; the First Hospital's communication with the Second Surgeon; and, the advice given by the OHS GP during the call on 26 December 2010.

The Ombudsman partly upheld Mrs P's complaints against the Practice and the Health Board. The Health Board, the Practice and the GP each agreed to implement the following recommendations.

- apologise for the failings indentified by this report;
- the Practice should liaise with the Health Board to arrange training for all staff involved in complaint handling;
- the Health Board should complete an audit of all discharges from the Ward on which Mr P was cared for, which have been completed within the last two months; the audit should analyse whether the failings identified by this report are still apparent and, if so, then the Health Board should implement refresher training for all ward staff (including physiotherapy staff if appropriate);
- the Health Board should complete an audit of student physiotherapy record-keeping from the last three months, to analyse whether the failings in physiotherapy record-keeping identified by this report, are still apparent; if so, the Health Board should implement refresher training for all physiotherapy staff (including qualified staff if appropriate);
- the Health Board should complete an audit of all final complaint response letters issued within the last month, to identify complainants have been properly advised of how to take their complaint further if they remain dissatisfied; if the audit identifies similar failings to those found by this investigation, the Health Board should contact those complainants to give them an apology and correct advice.

Aneurin Bevan Health Board – Appointments/admissions/discharge/transfer procedures
Case reference 201300049 – Report issued March 2014

Mr L complained to the Ombudsman about Aneurin Bevan Health Board ("the Health Board"). He said that his wife, Mrs L, was diagnosed with severe aortic stenosis and that she had been waiting more than a year for cardiac surgery. Mr L said he had complained to the Health Board about the delay and he was dissatisfied with the Health Board's response to his complaint.

The Ombudsman's investigation identified avoidable administrative delays in the Health Board's management of Mrs L's care along with several missed opportunities to take action to deal with those delays. The investigation also concluded that the Health Board's own investigation of the complaint should have identified, and apologised to Mrs L for, the failings this investigation found.

Following this investigation, the Health Board apologised for the failure to list Mrs L for an echocardiogram in March 2012. It acknowledged that there had been administrative delays and that the delay in a referral to a Specialist Hospital was unacceptable. The Health Board also apologised that a later "expedite" letter had not been sent. It said that it was in the process of implementing electronic referral and digital dictation systems which would address some of the issues identified by the investigation.

The Health Board also apologised for the confusion caused by its incorrect statement that it was not Government policy to offer long waiting patients treatment at an alternative hospital. It said that, since January 2014, it had been transferring the care of a small number of patients to England for cardiac surgery and that it intended to extend these arrangements.

The Health Board accepted the report and agreed to:

- give Mr and Mrs L a written apology for the failings indentified by this report;
- pay Mrs L £750 in redress in recognition of the anxiety and distress caused by the avoidable delays;
- formally remind the Cardiology Directorate of the Annual Leave Policy;
- formally instruct Cardiology Directorate clinicians of the requirement to ensure that onward referrals to other services, including tertiary care and the Specialist Hospital are dealt with promptly (in line with the Waiting Time Guidance);
- complete an independent audit of first 100 inbound referrals received by the Cardiology Directorate (excluding those to a named cardiologist) since 1 February 2014. The audit should identify whether there has been any similar failing to arrange necessary diagnostics (e.g. echocardiography). If indicated by the outcome of the audit, the process used by the Cardiology Directorate for dealing with inbound referrals should be revised and all relevant staff should be informed of the revised process;
- complete an independent audit of the first 50 onward referrals made by the Cardiology Directorate to other departments/ hospitals since 1 February 2014. The audit should identify the routine time taken between the decision to make a referral and the referral being sent. If the audit identifies unreasonable delays, the process used by the Cardiology Directorate for making onward referrals should be revised and all relevant staff should be informed of the revised process;
- discuss the Ombudsman's report and the results of both audits at the next meeting of the Cardiology Directorate's management team;
- provide evidence to this office that all the above recommendations have been completed.

GP in Hywel Dda Health Board area – Clinical treatment outside hospital
Case reference 201301065 – Report issued March 2014

Ms J was concerned about the care and treatment provided by a GP at the Practice during 2011. She felt that despite raising concerns with the GP on several occasions about her altered bowel habits and stomach distension, the GP failed to listen to her or carry out a physical examination. Ms J felt that had the GP done so, this may have avoided a delay in the diagnosis and treatment of her ovarian cancer. She also said that the explanation given to her by the GP following a review of her medical notes was inadequate.

The Ombudsman upheld the complaint about one appointment. Her clinical adviser felt that the treatment did not fall within the bounds of acceptable clinical practice and that a physical examination should have been carried out. She was unable to say whether this would have led to further investigation of Ms J's symptoms or an earlier detection of the cancer. Her clinical adviser also raised concern about the standard of record keeping. It was also felt that while the responses from the GP addressed Ms J's concerns, there was no recognition that a physical examination was called for during this appointment.

The GP/Practice agreed to implement the following recommendations:

a) apologise for the failings identified and offer £250 redress;
b) reflect on the issue of record keeping and raise the issue with the GP's appraiser at her annual GP appraisal;
c) the Surgery will ensure that cancer referral letters are clearly identified as such.

GP in the Aneurin Bevan Health Board area – Clinical treatment outside hospital
Case reference 201301483 – Report issued March 2014
Mr M was concerned about the care and treatment provided to him at the Practice on two occasions in March 2013. He was seen by a GP Registrar and a few days later, was seen by a Nurse Practitioner. He was concerned that both failed to diagnose that he had pneumonia. He felt that, had this been detected at either appointment, his condition would not have been so critical when he was eventually hospitalised. He was admitted to hospital some 12 hours after the consultation with the Nurse Practitioner and was diagnosed with pneumonia. Mr M spent 35 days in critical care.

The Ombudsman did not uphold his complaint against the GP Registrar. Her clinical adviser considered that the consultation fell within the boundaries of acceptable clinical practice. She upheld the complaint about his consultation with the Nurse Practitioner. Her clinical adviser identified a number of shortcomings which reduced the chances of an accurate diagnosis which included a lack of awareness regarding the significance of the duration of Mr M's illness, especially given his deterioration despite three days of antibiotics. Mr M should have been referred to hospital following his consultation with the Nurse Practitioner. The Ombudsman was unable to say whether the outcome would have been different in terms of Mr M's treatment and recovery if he had been hospitalised 12 hours earlier.

The Surgery agreed to implement the following recommendations:

a) write to Mr M to apologise for the failings identified and offer £150 redress;
b) arrange for the Nurse Practitioner to update her knowledge on the management of respiratory tract infections and provide evidence of learning from the complaint;
c) produce a nurse led protocol for the management of lower respiratory tract infections and for the management of urinary tract infections.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201301644 – Report issued March 2014

Mr G complained that he was discharged from hospital without having been diagnosed with heart failure. He complained that doctors failed to properly diagnose him and also failed to advise him against travelling to New Zealand two days after discharge. He also complained that his ongoing warfarin therapy was not appropriately organised. Mr G complained that he was therefore unable to enjoy his holiday and also had to pay for private medical treatment in New Zealand.

The Ombudsman found that Mr G had not been properly diagnosed and should have been robustly warned against travelling. The Ombudsman also found that doctors had failed to make adequate arrangements to monitor Mr G's warfarin therapy. The Ombudsman concluded that if doctors had properly diagnosed/advised Mr G, he probably would not have travelled to New Zealand or incurred medical treatment costs. The Ombudsman made the following recommendations:

a) the Health Board should provide Mr G with a comprehensive written apology for the failings identified;
b) the Health Board should pay Mr G redress in the sum of £700 in respect of the medical costs he incurred in New Zealand, the distress caused by the failings identified and the time and trouble to which he was put in pursuing this complaint;
c) the Health Board should review the failings identified in this report with the clinicians involved in Mr G's care and discuss them as part of their professional development/appraisal process.

Betsi Cadwaladr University Health Board – Complaints Handling
Case reference 201204442 – February 2014

The investigation examined the way Betsi Cadwaladr University Health Board (the Health Board) investigated Mrs A's complaint about her late husband's care at a GP surgery in the Health Board's area. Complaints about the NHS in Wales are handled under "Putting Things Right", the Welsh Government's guidance on dealing with concerns. The Regulations which provide the legislative framework for Putting Things Right allow for a complaint against a GP to be investigated either by the GP practice or by the relevant Health Board.

Putting Things Right states that "local health boards may not make any determination about the liability in tort of a primary care provider." The Ombudsman found that this would not preclude the Health Board from investigating, from reaching conclusions, or from finding fault with a GP practice. The Ombudsman upheld the complaint and found that the Health Board's interpretation of its role in respect of GP complaints was too restrictive.

The Health Board agreed to implement the following recommendations:

a) to apologise to Mrs A for its shortcomings in handling her concern about her husband's care;
b) to pay her the sum of £500 for her time and trouble in having to pursuing this matter to the Ombudsman's office;
c) to review its approach to investigating concerns and complaints about primary care, and to update its written procedures.

The Ombudsman shared her report with the Welsh Government as it is likely to affect the approach of other Health Boards in Wales.

Hywel Dda Health Board – Complaints Handling
Case reference 201302769 – February 2014
Dr B complained that the Health Board did not investigate a dental Practice with sufficient rigour after he referred a complaint to it. He said that the Health Board accepted without question the Practice's version of what happened when he turned up for an appointment. Dr B said that the Practice unfairly wrote to him thereafter, warning him about his future conduct. Moreover, the Health Board allowed the Practice to claim that a copy of a letter cancelling an appointment was a duplicate version of the letter that Dr B had received, when it clearly was not. This led to a dispute about the legitimacy of a further cancellation letter that Dr B did not receive.

The Ombudsman found that the Health Board had no reason to support or reject Dr B's version of events on the day in question. She concluded that there was no corroborative or indicative evidence on which to make a finding. The Ombudsman added that the warning letter was reasonable in the context of the Practice's version of events. She could not uphold those parts of Dr B's complaint. However, she criticised the Health Board for not taking a more rigorous approach to the Practice's presentation of a copy letter that was demonstrably not an exact copy and for accepting the explanation for the differences. She upheld that aspect of Dr B's complaint.

The Ombudsman recommended that the Health Board should:

a) apologise to Dr B;
b) pay him £50 for his time and trouble in raising a legitimate complaint;
c) take advice from the Information Commissioner's Office about data protection implications of how the Practice presented its copies;
d) tell the Ombudsman what it intended to do regarding how the Practice had handled the matter.

The Health Board agreed to implement the recommendations.

Cwm Taf Health Board & Betsi Cadwaladr University Health Board – Other
Case reference 201204407 & 201204700 – Reports issued February 2014
Mr F complained to the Ombudsman about the manner in which an Independent Hospital engaged with him in relation to the care and support being provided to his half brother, Mr S. The care for Mr S was commissioned by the Welsh Specialist Services Committee (WHSSC). Whilst Mr F raised no concerns about the quality of the care being provided to Mr S, he complained that the Independent Hospital had failed to recognise him as Mr S's nearest relative; had placed obstacles in his way as he tried to provide support and assistance to Mr S; had undertaken a mental capacity assessment in a flawed manner; and with the intention of preventing him from having access to Mr S's medical records. They were also concerned about the lack of advocacy support provided to Mr S and about discrepancies and omissions in Mr S's clinical notes.

The Ombudsman found that staff at the Independent Hospital had failed to communicate appropriately with Mr F, and that, having refused to recognise Mr F as Mr S's nearest relative, the Independent Hospital had then failed to undertake the appropriate enquiries to identify the nearest relative and failed to engage appropriately with Mr S's family and other professionals in that regard. The Ombudsman found that the Independent Hospital had failed to provide Mr S with adequate advocacy and that there were flaws in the mental capacity assessment that it carried out in order to establish whether Mr S had the capacity to consent to allow his clinical records to be shared with Mr F. The Ombudsman also found failings in the record keeping practices of the Independent Hospital which, whilst not impacting on Mr S's care, did make the process of pursuing the complaint difficult for Mr F. The Ombudsman upheld all the above aspects of the complaint and made the following recommendations of the Independent Hospital and WHSSC:
That WHSSC:

a) satisfy themselves, before commissioning any further care from the Independent Hospital, that it has addressed the shortcomings highlighted in the report;
b) engage with any responsible LHBs to provide advice, where needed, on the support any patients receiving care at the Independent Hospital or their families should be receiving in accordance with relevant mental health legislation;
c) remind any care provider it commissions services from for the need to maintain contact with the relevant Care Co-ordinator in the patient's home locality;
d) considers whether their framework agreement is sufficiently robust in relation to the Mental Capacity Act.

That the Independent Hospital:

a) apologise and pay the complainants redress of £1,500.

That the Health Board, which manages the local mental health team responsible for Mr S's current care (Betsi Cadwaladr University Local Health Board):

a) engage positively with Mr S and Mr F and any relevant professionals to determine the identity of Mr S's nearest relative.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201300572 – Report issued February 2014
The Ombudsman investigated Mrs C's complaint about her father, Mr B's, care at Singleton Admissions Unit (SAU) on 29 October 2012. Mr B had advanced cancer and sadly died that day.

The Ombudsman found that Mr B was not triaged or prioritised, and staff had no way of systematically assessing which patients had greatest need of clinical attention. Further, no pain assessment was done. An episode of vomiting signified an important shift in Mr B's condition, but medical staff were not notified of this. Abertawe Bro Morgannwg Health Board said it had no proper process at the time to review a patient's priority. The SAU had since introduced a more robust process for triaging and prioritising patients. The Ombudsman upheld the complaint, finding that Mr B spent some of the last few hours of his life in severe and unrelieved pain.

The Health Board agreed to implement the following recommendations:

a) apologise fully to the family for the failings identified, and provide them with information about the actions being undertaken to improve processes within the SAU;
b) pay the sum of £750 in recognition of the distress caused by the Health Board's failings;
c) share the Ombudsman's report with nursing staff who were involved in Mr B's care and with senior SAU staff, so they are aware of the lessons to be learned from it;
d) undertake a review of the current triage/early warning system to ensure it is working appropriately;
e) ensure that nurses working in the SAU are trained in the use of the triage system;
f) identify criteria for the skills and level of experience required by nurses before they can undertake the triage role;
g) review the Royal College of Physicians' Acute Medical Task Force 2007 report to ensure that its recommendations have been implemented.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201301412 – Report issued February 2014

The investigation considered aspects of the management of Mrs A's pregnancy in 2010, which sadly ended in a miscarriage at 20 weeks.

The Ombudsman did not uphold Mrs A's complaint that there was no investigation of bleeding in early pregnancy. Nor did she uphold the complaint that Duphaston (a form of artificial progesterone which is no longer available in the UK, although alternatives are) tablets were not given to stop bleeding as guidance issued by the National Institute for Health and Care Excellence does not recommend the use of artificial progesterone. However, the Ombudsman found that Mrs A was not given adequate pain relief when she spent the night on a gynaecological, not an obstetric, ward, and upheld this aspect of her complaint. The Ombudsman also partly upheld a complaint that there was a delay in identifying retained placenta following the miscarriage as the Health Board did not send a discharge letter to Mrs A's GP which would have indicated the possibility of this.

The Health Board agreed to implement the following recommendations:

a) apologise fully to Mrs A for the failings identified;
b) pay Mrs A the sum of £500 to recognise the additional distress she experienced as a result of the Health Board's failings;
c) conduct an audit of obstetric discharge letters following second trimester pregnancy loss to confirm that they are routinely sent, and contain relevant information.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201204771 – Report issued February 2014
Ms A complained about the care and treatment provided at the Royal Gwent Hospital from 2006 to 2012. Specifically, Ms A complained about the time taken to diagnose her breast cancer and subsequently to detect her bone metastases disease. Ms A also complained that the Health Board's response to her complaint was delayed and said that the response did not address all of her concerns.

The Ombudsman partly upheld the complaint. Having obtained professional advice on the clinical aspects of Ms A's care, the Ombudsman found that Ms A's consultations were carried out in accordance with expected standards. In particular, the time taken to reach a diagnosis of Ms A's breast cancer and the subsequent action taken was reasonable. However, the evidence confirmed that there were shortcomings in the handling of Ms A's complaint. There was a delay in providing a response to her concerns in accordance with the complaints handling guidance "Putting Things Right".

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300813 – Report issued February 2014
Mr B complained about the treatment he received for colon cancer between 2011 and 2012. He believed that this should have been diagnosed earlier than it was, that there were errors in the surgery which he underwent and that he was discharged from hospital prematurely. He also expressed concern about the Health Board's proposal to transfer his care to an alternative hospital following his complaint.

The Ombudsman partly upheld the complaint. She found that the Consultant had not discussed the possibility of a further biopsy with Mr B when an initial biopsy was inconclusive, although she believed it was unlikely that the Consultant would have advised such a course in any event. She found that Mr B had not been given sufficient information about the procedure and the possible risks, and had therefore not been prepared for the difficulties he had experienced. However, the Ombudsman found that the surgery had been carried out to a reasonable standard, and that there was no evidence that he had not been fit for discharge. Whilst the Ombudsman considered that the suggestion of transferring Mr B's care to another hospital might have been appropriate it could have been handled better.

The Health Board agreed to:

• apologise to Mr B for the failings identified;
• in recognition of the additional distress experienced by Mr B by reason of these failings, make a payment to Mr B in the sum of £750 remind staff of the General Medical Council consent guidance and the importance of keeping records of discussions with patients

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201203193 – Report issued February 2014

Mr A complained about the care provided for his late father, Mr B. Mr B had rheumatoid arthritis. Mr A said that the Health Board should have completed a chest X-ray, in respect of Mr B, during the twelve months that preceded his adalimumab treatment (Adalimumab blocks the inflammatory effect of tumour necrosis factor alpha [TNFα, a protein produced by the cells inside joints]; it is a major contributor to inflammation in diseases like rheumatoid arthritis, and Adalimumab treatment is a form of anti-TNFα treatment). He said that it should have referred Mr B to a cardiology specialist when it admitted him to the University Hospital of Wales. He said that it should have prescribed blood-thinning medication for him, transferred him to a specialist ward earlier and completed a CT scan of his abdomen sooner (CT - Computerised Tomography; a scan which involves scanning the body with a series of X-rays; a computer then assembles the X-rays to produce detailed images of internal structures within the body, such as organs and blood vessels). He suggested that it should have diagnosed his bowel ischaemia (insufficient supply of blood to an organ) more quickly. He said that a Consultant Surgeon ("the Surgeon") delayed his treatment unnecessarily. He suggested that the Health Board's management of Mr B's pain, after his surgery, was lacking. He was dissatisfied with the Health Board's response to his complaint because it took a long time to provide it and did not give him a copy of the Surgeon's statement.

The Ombudsman did not uphold the clinical aspects of Mr A's complaint; however, the Ombudsman did uphold the complaint handling part of it. She considered that the Health Board took too long to respond to Mr A's complaint, failed to explain this delay to him at the appropriate time and to update him. She recommended that the Health Board should:

a) apologise for the complaint handling failings identified;
b) explain to Mr A why it took so long to respond to his complaint; and,
c) send him a copy of the Surgeon's statement.

The Health Board agreed to comply with these recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204082 – Report issued February 2014

Mrs A's complaint concerns the failure by doctors treating her husband to diagnose cancer. Mrs A said that she believed that her husband's cancer had been present in 2010. Mrs A also complained about the delays in the Health Board dealing with her complaint.

The Ombudsman's investigation concluded that Mr A's cancer was present in 2010 and was critical that the diagnosis was missed by those treating him and upheld this aspect of Mrs A's complaint. The Ombudsman concluded that the Health Board's delay in dealing with Mrs A's complaint was unreasonable. She expressed concern that as a consequence, the Health Board's ability to learn lessons from Mrs A's complaint was compromised. The Ombudsman upheld Mrs A's complaint.

The Ombudsman recommended that the Health Board should:

a) provide a fulsome apology to Mrs A both for the significant clinical failing identified and for the inadequate handling of her complaint. Provides financial redress of £2,000 to Mrs A for the distress caused by the failings identified; and a further £500 to Mrs A in recognition of the shortcomings in complaint handling;
b) ensure that clinicians are reminded of the importance of patient involvement in the management of their care and treatment, and also of the need to perform further biopsies and seek specialist advice in cases where tests have shown conflicting results;
c) as part of a wider learning process, discuss with the members of the UGI MDT involved in Mr A's care, consider the issues raised in this case and the learning points that arise.
d) discuss the contents of this report at an appropriate consultant forum across the Health Board;
e) share a copy of this report with the Chairman of the Health Board;
f) carry out a root cause analysis of the failings in respect of complaint handling identified in this report and provide its findings to this office.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300754 – Report issued February 2014
Mr W complained about the care and treatment he received in hospital following his Trans-urethral resection of Prostate surgery. He was concerned that his warfarin therapy was not managed appropriately, that the monitoring of his urine output was insufficient and that his discharge was premature.

The Ombudsman upheld his complaints. The Health Board confirmed that the instructions of the anti-coagulation clinic were followed. These were contrary to the instructions of the operating surgeon, which her clinical adviser said should have been followed. She also found that the fluid balance charts were inadequately completed and there was insufficient evidence to make an informed decision on discharge. The Health Board had already accepted during its investigation that its routine procedure for urine monitoring was not followed and that Mr W was prematurely discharged.

The Health Board agreed to implement the following recommendations:

a) reinforce the apology for the failings identified and make a payment of £100 in acknowledgement of the distress of being inappropriately discharged;
b) provide evidence of the random spot checks carried out to ensure compliance with its procedure for urine analysis on removal of catheter;
c) provide evidence of the training it has already organised, together with details of how it proposes to ensure that such training forms part of the ongoing development of all relevant staff;
d) issue a reminder to staff on the Ward of the importance of good record keeping and the need to ensure that fluid balance charts contain all necessary information. This should form part of the training that the Health Board has already organised;
e) carry out a feasibility study into the use of bladder scanners for all urology patients following catheter removal;

f) demonstrate that it has in place an appropriate risk assessment procedure which ensures that urological patients being treated on a general ward are appropriately prioritised for transfer to a specialist urology ward where possible;
g) review the conflicting anti-coagulation regimes recommended by the operating surgeon and the anti-coagulation clinic and, in light of the clinically significant differences between the two approaches, ensure that recognised good practice (with reference to any applicable guidance) is consistently followed by all relevant staff;
h) ensure that it has a procedure in place so that recommendations from the anticoagulation clinic for post-operative care are brought to the attention of the operating surgeon pre-operatively and where differing approaches arise, the rationale for preferring one over the other is discussed and clearly documented in the patient record.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201203947 – Report issued January 2014
Mrs X complained about the care and treatment provided to her late brother, Y, during his admission at Royal Glamorgan Hospital in March 2012. Mrs X considered that the care her brother received was below a reasonable standard and specifically raised issues about his medication, delays in the provision of nutrition, the nursing care received and a lack of communication with the family about Y's condition during the period. Y died in hospital twelve days after his admission; Mrs X considered that she and her family were not given crucial information about his condition which could have led to a more dignified passing for Y at home.

The Ombudsman concluded that the care and treatment provided to Y during the period of admission, including his medication, was generally of an acceptable standard. Nevertheless, the Ombudsman identified failings in respect of the delay in the completion of a dietetic assessment and provision of nutritional support for Y within the early stages of his admission. The Ombudsman also determined that there had been a failure to fully comply with National Guidance in respect of the end of life care discussions and arrangements. Whilst, the Ombudsman found evidence which was suggestive that information about Y's condition had been given to his family in a timely manner, it appeared that the communication was not as effective as it could have been. Whilst this was not identified as a failing, the Health Board was nevertheless asked to consider this as a matter for service improvement.

The Ombudsman recommended that the Health Board should:

a) provide a written apology to Mrs X for the failings identified;
b) pay Mrs X £500 to recognise the distress caused by knowledge of the failings identified and £250 in respect of her time and trouble in pursuing this complaint;
c) review its procedure and provision for emergency feeding outside the times of its usual Dietetic Service;
d) provide this office with evidence of an analysis of Y's care, any action points and the outcome of the same;
e) provide a copy of the final report of this investigation to all the staff involved with Y's care for reflection.

Betsi Cadwaladr University Health Board – Appointments/admissions/ discharge/ transfer procedures
Case reference 201203515 – Report issued January 2014
Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to recognise the effect a residential setting would have on her mother, Mrs Z's, needs or take into account the effect of arthritic pain on Mrs Z's mental health. Mrs X also complained that the family were excluded from the original assessment process and that there was a failure to conduct any additional assessments. Finally Mrs X complained that the Health Board had failed to adequately respond to her complaints.

The Ombudsman found that, in view of Mrs Z's condition, it was reasonable to place her in a care home; however, there was no evidence that the effects of Mrs Z's condition were considered when finding a placement. Additionally, Mrs Z's records showed a link between her struggling with her daily tasks and her challenging behaviour, yet those links were not recognised. The Ombudsman also noted that, given their first hand knowledge of her condition, it would have been good practice to include Mrs Z's family in the assessment process, and to have arranged regular reviews. Finally, the Ombudsman found that the Health Board had failed to adequately respond to Mrs X's complaint.

It was recommended that the Health Board should:

• apologise to Mrs X for the service failure identified in the report;
• pay Mrs X the sum of £250 in recognition of the time and trouble in bringing her complaint to this office;
• remind the relevant staff that where appropriate, information on the differences between care homes and care homes with nursing should be explained to patients and their families/carers;
• remind the relevant staff that where appropriate, patients and their families/carers should be provided with information on how to request a mental health review and a NHS Continuing Health Care funding review;
• remind the relevant staff that where appropriate, it would be considered good practice to include a patient's family/carer in the assessment process;
• include within its training plan training for the relevant staff on the links between pain and challenging behaviour in patients with dementia.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201302513 – Report issued January 2014
Mrs A complained that her late mother, Mrs W, had complaint of cramps in her leg after treatment for a broken ankle. Mrs A said that at her mother's outpatient's appointments that her mother continued to complain about cramps and a throbbing in her leg. She was referred to physiotherapy but unfortunately passed away before her appointment.

Mrs A said her mother presented with the symptoms for DVT and she should have had a Doppler scan which would have saved her life. Her mother was not given a surgical stocking after her operation.

The Adviser said that Mrs A's symptoms were consistent with DVT, but, in this instance, they were equally consistent with her post operative progress. The Adviser said that, without the benefit of hindsight, there was insufficient evidence to justify a Doppler scan, which was a reasonable response. The Adviser said that there was no evidence for Mrs A to have had surgical stockings as well as her warfarin treatment. Mrs A's physiotherapy appointment had been within the prescribed time limit. In response to Mrs A's complaint, the Registrar said that Mrs W had complained of cramps which he had not recorded in the medical notes.

It was recommended that, within one month of this report, the Health Board should:

a) highlight to the Registrar the importance of recording patient's symptoms;
b) the Consultant surgeon to discuss this case with colleagues;
c) review the policy of administrating warfarin in preference to low molecular weight heparin.

Within two months of this report, the Health Board should:

a) forward the Orthopaedic Department's policy for the prevention of DVT in long term immobile patients including those in the community.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201203424 – Report issued January 2014

Mrs P complained about the treatment and care given to her late husband, at Glangwili General Hospital, when he presented with abdominal pain. Sadly he died a few days later from bilateral pulmonary emboli (Blood clots blocking the artery of both lungs; most commonly, the condition results from a deep vein thrombosis that breaks off and migrates to the lungs). She said that appropriate nursing care was not given and nursing staff did not take into account that her husband had Parkinson's disease. She also said that her husband was not given the appropriate medical treatment (medication and stockings) to prevent DVT (Deep vein thrombosis – a clot of blood which most often occurs in the deep veins of the leg and pelvis and may dislodge and travel to the lungs to form a pulmonary embolism) even though he was admitted to a surgical ward where such treatment was standard.

The Ombudsman found that there were some shortcomings in nursing care, which to its credit the Health Board had already acknowledged. The record of Mr P's fluid intake was confusing and unreliable and his medication had not been stored appropriately. However Mr P's condition had been recognised and taken into account to a certain extent and there was no absolute failure. Regarding medical care the Ombudsman said that there were some factors which may have made preventative measures unsuitable/unnecessary for Mr P. But there was no evidence that the risks of DVT had been properly assessed in his case and no recording of the reasons for not giving the usual preventative measures, which was poor practice. However the Ombudsman recognised the clinical difficulties in this case because Mr P was not presenting with the usual symptoms of DVT. Based on his medical advice, the Ombudsman could not say that the outcome would have been any different had the identified shortcomings not occurred.

The Health Board agreed to apologise to Mrs P and to provide evidence that the following recommendations had been complied with:

1) to audit the use of the risk assessment form for acute surgical admissions and the recording of the reasons where preventative measures were not prescribed;
2) to ensure systems were in place to monitor at ward level, compliance with local and national standards on safe medicine management and to make sure that patients with Parkinsons disease were given their usual medication, which could be outside the usual drugs round;
3) to audit the completion of fluid intake charts and their accuracy.

Cwm Taf Health Board – Clinical treatment outside hospital
Case reference 201203653 – Report issued January 2014
Mr P complained about his post-operative wound care by the District Nursing Service following a knee replacement. He said that the wound did not heal quickly because of poor and inconsistent care which resulted in a second operation to clean and re-stitch the knee.

The Ombudsman found that there were a number of fundamental shortcomings in Mr P's care. There were failings in wound care management because there was no initial assessment and overall care plan. Also, there were inconsistencies in the type of dressings applied and no recorded explanations for the changes. On two occasions the dressings were found to be inappropriate. The investigation was not helped by the standard of note keeping which was poor and incomplete.

Overall, although certain aspects of Mr P's complaint were upheld, the Ombudsman could not say with any certainty that the shortcomings directly delayed the healing process or that the outcome would have been any different had the shortcomings not occurred. The Health Board agreed to apologise to Mr P for the failings identified and to:

1) ensure systems were in place to require nursing assessments and treatment plans for longer term patients;
2) carry out audits to show this had been done;
3) put in place training for team members on record keeping and wound care management.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201204630 – Report issued January 2014
Mrs N complained about the care and treatment provided to her father, Mr M, who was admitted to Singleton Hospital with a suspected stroke on a Friday afternoon. He was referred to the Hospital's Admissions Unit (AU) by his GP, in accordance with local protocol, and later on he was transferred to a ward. The dedicated Stroke Unit for the Health Board is located at another Hospital (Morriston). Mr M suffered from a particular blood disorder (known as ITP), being already under the care of Haematologists. Mrs N complained that Mr M was not given any active treatment, was not seen by any Consultant over the weekend despite the family's concerns, and that his condition

deteriorated into a dense stroke from which he never fully recovered. Mr M passed away some 18 months later, during the investigation. Mrs N felt her father's care was compromised by it being a weekend, citing comments made by junior staff, and that this had affected the outcome for him. She also complained about the manner of the Registrar on duty's communication with the family and about how the Health Board had dealt with her complaint.

The investigation found that there were failings in Mr M's management, which were very likely contributed to by weekend staffing arrangements. After transfer to a ward from the AU on Friday evening, no Consultant review took place until the Monday morning when he was seen by both a Stroke and a Haematology Consultant. Guidance stipulates that there should be a review within 24 hours of a transfer from an AU and, given the drug Mr M took for his ITP, a Haematology review was mandated because an event had happened whilst he took it. Mr M was also not considered for a transfer to a dedicated stroke ward when, at certain points, a bed became available. However, the Ombudsman's clinical advisers felt this would not have altered the sad outcome for Mr M – active treatment for a stroke (thrombolysis, commonly called the 'clot-busting' drug) can only be given within a small window of opportunity after symptoms begin. In Mr M's case, his symptoms were noted as starting the previous day, if not earlier, so it was too late to offer him active therapy on admission.

Criticisms were made about how Mr M was managed, and the communication with the family. In addition, the Health Board's Stroke Policy required urgent revision as it lacked clarity. There had also been an undue delay in responding to Mrs N's complaint. The following recommendations were made, all of which were agreed to by the Health Board:

a) apologise to Mrs N for the failings identified and redress of £500 for the poor complaint handling;
b) issue a reminder about the need for a Consultant review within 24 hours of both acute admissions and transfers on from the AU to wards;
c) issue a reminder to junior doctors about the availability of on-call Consultants and their general availability for advice at the weekend;
d) review the Stroke Policy.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201201407 – Report issued January 2014

Mrs C complained about the care provided for her late maternal grandmother, Mrs M, by Cardiff and Vale University Health Board ("the Health Board"). Her complaint concerned the Health Board's management of Mrs M's admission, ward transfer, oxygen therapy, oral care, nutrition, hydration, personal hygiene, pain and palliative care.

The Ombudsman partly upheld Mrs C's complaint. She considered that the Health Board failed to specifically assess and plan Mrs M's oral care, to record its provision consistently, to demonstrate that it confirmed the position of Mrs M's nasogastric tube ("NGT"), to investigate her ongoing breathing difficulties appropriately and to involve a Respiratory Physician in her care. She recommended that the Health Board should:

a) write to Mrs C and Mrs L, Mrs C's mother, to apologise for the failings identified;
b) share the investigation report with staff members and discuss it in an appropriate forum;
c) formally remind staff members to record the provision of oral care consistently;
d) consider introducing specific oral assessment and care planning documentation;
e) formally remind staff members to complete and record NGT positional checks;
f) formally remind staff members to complete fluid charts;
g) arrange to complete random audits of its Intentional Rounding Scheme documentation;
h) introduce a care pathway for the investigation of persistent breathing difficulties with an unconfirmed diagnosis.

The Health Board agreed to comply with these recommendations.

Cwm Taf Health Board – Clinical treatment in hospital
Case reference 201203378 – Report issued January 2014
Mr J complained about the inpatient care provided for his late mother, Mrs G, by Cwm Taf Health Board ("the Health Board"). He said that its assessment and management of her falls risk was lacking. He contended that it took too long to X-ray her right leg following a fall. He suggested that it gave her inadequate pain relief after this fall. He told us that it should have operated on Mrs G's fractured leg earlier. He said that its decisions to postpone this operation were unreasonable. He indicated that it should have told him that Mrs G had vascular dementia (A disruption in the brain's blood supply causes vascular dementia, which is a mental disorder) sooner. He also complained about its complaint handling because the first local resolution meeting was aborted and the Consultant Physician indicated, during the second meeting, that she would not change her practice.

The Ombudsman partly upheld Mr J's complaint because she considered that the Health Board delayed Mrs G's operation unreasonably and that its assessment and management of her falls risk was deficient. She also noted that it did not keep records of the first local resolution meeting and that some of the information, in the Chief Executive's letter to Mr J, was misleading. She recommended that the Health Board should:

a) write to Mr J to apologise for the failings identified;
b) ensure that it keeps records of all complaint-related meetings;
c) ensure that its management of hip fractures complies with relevant guidance;
d) provide training related to its Falls Procedure.

The Health Board agreed to comply with these recommendations.

Velindre NHS Trust – Clinical treatment in hospital
Case reference 201203816 – Report issued January 2014
Mrs C complained about the care provided for her late maternal grandmother, Mrs M, by Velindre NHS Trust ("the Trust"). Her complaint concerned the Trust's management of Mrs M's radiotherapy treatment (using radiation to kill cancer cells or to stop them from multiplying) and its side effects, its response to her breathlessness, and her nutritional and pressure ulcer-related care.

The Ombudsman partly upheld Mrs C's complaint. She considered that the Trust failed to seek specialist advice from Cardiff and Vale University Health Board promptly, to ensure that Mrs M's ongoing breathing difficulties were investigated appropriately, to comply with her dietary care plan and to complete her Food Record Charts ("FRCs") fully. She recommended that the Trust should:

a) write to Mrs C and Mrs L, Mrs C's mother, to apologise for the failings identified;
b) share the investigation report with staff members and discuss it in an appropriate forum;
c) revise its current care pathways to make sure that robust arrangements are in place to ensure that patients, with persistent breathing difficulties, are investigated in a timely manner;
d) formally remind staff members that they should always complete FRCs fully and record the provision and rejection of all nutritional supplements on them.

The Trust agreed to comply with these recommendations.

Cardiff and Vale University Health Board – Other
Case reference 201300841 – Report issued January 2014
Mr A complained about the care and treatment his 77 year old mother ("Mrs B") received during her stay at University Hospital Wales between 5 May and 27 June 2012. Mrs B had a history of chronic obstructive pulmonary disease, atrial fibrillation, hypothyroidism, polymyalgia rheumatic and temporal arteritis. In May 2012, she was admitted to hospital with a suspected stroke. She was then diagnosed with a benign brain tumour and was an in-patient whilst waiting for surgery. Mrs B required two emergency operations for a perforated bowel that she did not have on admission. Sadly she died on 27 June. Mr A was concerned that the perforated bowel was caused by poor nursing care and by decisions taken by doctors. He complained to the Health Board, but he did not receive a reply until 8 March 2013. He said the response ignored his complaint that poor nursing care caused the perforated bowel which, he said, led to his mother's death.

The investigation found no evidence that the decisions taken by doctors, or the standard of nursing care, were direct or contributing causes of Mrs B's perforated bowel. Mrs B was at high risk of perforation due to steroid use (for a pre-existing condition) and a CT scan showed evidence of extensive diverticular disease. Therefore, the Ombudsman did not uphold this part of Mr A's complaint. The investigation did conclude that the Health Board's handling of his complaint was poor. The Ombudsman upheld this part of the complaint because the Health Board's investigation failed to consider his allegation of negligence and the time taken to respond to him was excessive.

The Health Board accepted the report and agreed to provide evidence to show that it had complied with the Ombudsman's recommendations that it should:

a) give Mr A a written apology for the failure to follow the statutory guidance when considering his complaint;
b) pay Mr A £250 for the time and trouble taken to make his complaint;
c) share the report on this investigation with all staff involved in the Health Board's consideration of his complaint, to ensure that they are aware of the need to comply with the statutory guidance;

d) formally instruct the staff involved in considering and investigating his complaint that they must ensure that, when a complaint involves an allegation of negligence or harm, the investigation, investigation report and final response must comply with statutory guidance;
e) formally instruct the nursing and clinical staff involved in this case to follow the relevant record keeping guidance;
f) give this office evidence of the systems it has put place to monitor the impact of the actions it has taken, or is taking, to address the communication failings identified by Mr A's complaint to the Health Board;
g) provide the Older People's Commissioner for Wales's report entitled: "Dignified Care?" to all staff who were involved in his mother's care when she was on the ward.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201300132 – Report issued January 2014
Mr C complained about the standard of care and treatment provided to his mother-in-law, Mrs P, at Ysbyty Gwynedd, Bangor, in October 2011. In particular, he complained that there was a failure to initially identify that Mrs P had fractured her shoulder and broken more than one rib. He complained that there was also a failure to complete a manual handling assessment correctly. Mr C believed that as a result, Mrs P was caused more pain than would otherwise have been the case. Mr C was also dissatisfied with the way the family's complaint was dealt with by the Health Board.

The Ombudsman found that the fracture of Mrs P's shoulder should have been identified sooner than it was. The radiology report on an X-ray carried out shortly after Mrs P's admission was imprecise and did not make clear that there was a new fracture at the sight of a fracture Mrs P had suffered four years previously. In any event it was not clear that the treating doctors had seen the report. The fracture of Mrs P's shoulder was not identified until a further X-ray was carried out 10 days after her admission to hospital. The Ombudsman also found that the manual handling assessment was incomplete. She concluded that both these failings are likely to have caused Mrs P some additional pain and distress and she upheld these parts of the complaint. The Ombudsman did not uphold the complaint about the failure to diagnose of the rib fractures. The Ombudsman upheld the complaint about the handling of the family's complaint.

The Ombudsman recommended that the Health Board should:

1) provide a written apology to Mrs P and her family for the failings identified in this report;
2) pay Mrs P £150 to recognise the additional pain and discomfort she was caused due to the delay in diagnosing the fractured shoulder and the failure to carry out an adequate manual handling assessment;
3) pay Mr C and Miss P £100 each to reflect the time and trouble they were put to in pursuing the complaint due to the failings in the way the matter was handled by the Health Board;
4) provide this office with evidence that it has reviewed the effectiveness of the changes it has made in relation to pain and manual handling assessments.
5) remind its radiologists of the need for clarity in reports where a fracture has occurred at or around the site of a previous fracture.

6) provide this office with evidence that it has implemented National Patient Safety Alert 16 and in particular that it has satisfactory systems in place to ensure that requesting clinical teams are made aware of radiology reports.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201204402 – Report issued January 2014
Mrs A complained that following her father's hip replacement surgery in 2008 he continued to report being in pain during the period 2009 to 2012. Mrs A also complained that during the course of her father's physiotherapy and hydrotherapy sessions his continued reports of persistent pain were not adequately addressed and that there was a delay in referring her father back to the orthopaedic surgical team.

The Ombudsman's investigation found that the medical care that Mrs A's father received was adequate. However the investigation highlighted shortcomings in relation to the physiotherapy care that Mrs A's father received and this aspect of her complaint was upheld.

The Ombudsman recommended that the Health Board should:

a) within one month of the date of this report write to Mrs A to apologise for the failings identified by the investigation and pay a sum of £250 for the failure to refer Mrs A's father to the Orthopaedic Team which resulted in additional delay to see the Surgeon;
b) remind Consultants of ensuring any referral back to them is clearly documented in the referral letter;
c) provide documentary evidence of action it has taken to remind its staff of the documentation standards and discharge process for patients accessing hydrotherapy.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201204652 – Report issued January 2014
Mrs A complained about removal of a "wart like growth" under her right big toe carried in Wrexham Maelor Hospital ("the Hospital"). She complained that following surgery she was with diagnosed chronic pain syndrome. Mrs A also complained about the poor care she received from the District Nursing team. Finally, she complained about the Health Board's handling of her complaint.

The Ombudsman's investigation found inadequacies in record keeping and consent process by the Surgeon which the Ombudsman considers did not meet the requirement of the General Medical Council and to that limited extent upheld this aspect of Mrs A's complaint.

The Ombudsman learned during the course of the investigation that the Health Board had misplaced Mrs A's medical records. She considered that loss of the records impeded her ability to fully investigate this aspect of Mrs A's complaint and reach an appropriate finding. The Ombudsman concluded that this caused Mrs A injustice and that the Health Board's failings amount to maladministration of Mrs A's complaint. She also found shortcomings in the Health Board's handling of Mrs A's complaint. Mrs A's complaint was upheld.

The Ombudsman recommended that the Health Board should:

a) apologise to Mrs A for the shortcomings identified by the investigation and make a payment of £350;
b) consider the points raised in relation to consent and the recording of consultation in the patient's medical records. Consider whether there needs to be a Health Board wide review of its consenting procedure particularly in relation to elective surgical procedures;
c) should review the circumstances of this case and consider any improvements it needs to make to its systems for tracking, filing and locating original medical records in its possession, to ensure that its systems are robust.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201204671 – Report issued January 2014
Mrs P complained that, following a hysterectomy carried out in Glangwili General Hospital ("the Hospital"), she was admitted to the Hospital via the A&E Department with a history of vaginal bleeding. Mrs P's complaint concerned the failure to carry out a scan when admitted to the Hospital resulted in additional pain and suffering to her and her family.

The Ombudsman's investigation concluded that there were shortcomings in the clinical management of her condition which resulted in a further readmission to the Hospital. Mrs P's complaint was upheld. The Ombudsman recommended that the Health Board should apologise to Mrs P for the shortcomings identified in her care.

GP in Abertawe Bro Morgannwg University Health Board area, Pharmacy in the Abertawe Bro Morgannwg University Health Board area & Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital
Case references 201203584,201203822 & 201302460 – Reports issued January 2014
Ms R complained that her son was prescribed an overdose of the drug lamotrigine (50mg per day instead of 4 mg) by a local GP. The drug was dispensed by the local pharmacy and Ms R's son suffered a reaction which required hospital treatment.

The Ombudsman upheld the complaint. The prescribing error was the responsibility of the GP concerned. However, there were also shortcomings in the pharmacy procedures which could have identified the error at the point of dispensing. The Ombudsman also identified that the Health Board could improve its procedures for monitoring GPs within its area. The Ombudsman obtained clinical advice which confirmed that Ms R's son would not have suffered any long term effects from the overdose.

The Ombudsman recommended that the GP should:

• give a written apology to Ms R;
• ensure that he undertakes OHS assessments as arranged by the Health Board;
• make a payment of £500 to Ms R in recognition of the distress caused to Ms R's son, and her time and trouble in pursuing her complaint.

The Ombudsman recommended that the Health Board should:

• ensure that it has robust processes in place for monitoring GPs within its area, where there are identified issues that require follow up. It should ensure that appropriate Occupational Health and Safety (OHS) assessments are provided and completed where necessary.

The Ombudsman recommended that the Pharmacy should:

• give a written apology to Ms R for the procedural shortcomings at the time of dispensing;
• take note of comments made about its complaint investigation process;
• make a payment of £150 to Ms R in recognition of its role in the distress caused to Ms R and her son by the drug overdose.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201204230 – Report issued January 2014

Mrs B complained about the standard of care provided to her late mother, Mrs A. She complained that Mrs A was inappropriately diagnosed and treated with steroids for ABPA (Allergic Bronchopulmonary Aspergillosis - a respiratory condition). She further complained about aspects of Mrs A's hospital treatment following surgery for a perforated bowel. Sadly Mrs A died following that surgery.

The Ombudsman sought clinical advice on Mrs B's complaint. As a result of that advice, it was concluded that the diagnosis and treatment of Mrs A's ABPA was appropriate. The Ombudsman did make some criticism in relation to Mrs A's antibiotic treatment, in that further blood cultures should have been taken and antibiotic therapy reviewed when she exhibited a raised temperature. She partly upheld this aspect of the complaint. The Health Board agreed to review the microbiology input into Mrs A's care and to ensure that any learning points were shared with relevant staff.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201203882 – Report issued January 2014

Mr X complained about the standard of care provided to him in September 2012 when he was admitted to a mental health unit on the Wrexham Maelor Hospital site. He complained that the Health Board was late in responding to his complaint; that he was not, because of a faxing error, provided with medication when he should have been; that a diagnosis of "personality disorder" was made (where his current diagnosis had been of a "schizoaffective disorder"); and that there were other shortcomings in his care related to that admission.

The investigation found that, while the Health Board had delayed before responding to the complaint, it had apologised appropriately for the delay and provided a reason for it. The Health Board acknowledged the faxing error, apologised for it and took reasonable steps to make a recurrence less likely. These two complaints were not upheld. On the discharge summary, Mr X was noted as having a "personality disorder" when no diagnostic assessment had been undertaken. This caused Mr X distress and the complaint was therefore upheld. The other related complaints were not upheld.

It was recommended that the Health Board:

a) apologise to Mr X for recording that he had a "personality disorder" when no diagnostic assessment had been undertaken, and for the distress that this caused him;
b) include an entry in Mr X's records which made it clear that the reference to his having a "personality disorder" was made in error and should be disregarded;
c) make a payment of £150 to Mr X in recognition of the distress he was caused.

Other reports - Not Upheld

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201302409 – Report issued March 2014
The investigation considered Mrs X's care and treatment following a silent miscarriage in April 2013 when she was 5-6 weeks pregnant. Mrs X complained about the administration of medication in the medical management of the miscarriage, in that her body had not absorbed the second dose of medication, and about a lack of action when she had heavy bleeding for an extended time following the miscarriage.

The complaints were not upheld. The guidance (Ectopic Pregnancy and Miscarriage, published in December 2012) issued by the National Institute for Health and Social Care and introduced shortly before these events, indicated that the second dose of medication was unnecessary. The Health Board agreed to check that it has since updated its internal procedures for medical management of miscarriage in line with the NICE guideline. Further, while Mrs X's experience of continued bleeding was frightening and distressing, there was no failure of care. Although she had been told to contact the ward if she had any problems, it was subsequently reasonable for the hospital to direct her to seek treatment through her GP and A&E. However, the Health Board agreed to share the Ombudsman's report with the senior nurse responsible for the ward to note Mrs X's experiences.

GP in Cardiff and Vale University Health Board area – Clinical treatment outside hospital
Case reference 201302266 – Report issued March 2014
Mrs X complained that there had been a failure by the GP to arrange medical assessment and to diagnose and treat her young daughter in a timely manner following a telephone call made on 11 December 2012. She was concerned that the GP had not sought to examine Miss X and had instead simply given out telephone advice. Mrs X was concerned that this advice was based on a five year old child's self diagnosis. Mrs X referred specifically to the matter that pneumonia had been allowed to develop in her daughter's case. Mrs X said that a couple of days later she arranged for an urgent GP appointment and Miss X collapsed in the surgery and was taken to the Emergency Department with acute pneumonia. Mrs X was also dissatisfied with the GP's complaint response to her.

In considering this complaint the Ombudsman took advice from one of his clinical advisers, an experienced GP. Taking account of this advice, the Ombudsman concluded that the GP carried out a reasonable telephone assessment. The GP took an adequate history and, based upon this,

decided not to undertake a face to face assessment to examine Miss X. This was in accordance with General Medical Council Guidance. The Ombudsman recognised that the GP asked relevant questions of Mr X regarding the general condition of his daughter, in particular ascertaining that there was no fever which might have indicated a more serious infection.

The GP then provided suitable advice for dealing with an ear infection and made it clear that Mr X could call the surgery if there were further concerns. Clinical advice suggested that it was unusual for a child of this age to develop such a serious pneumonia. The Ombudsman was of the view that it was not possible for the GP to have anticipated the unfortunate events that took place subsequently in this case.

The Ombudsman concluded that there was no evidence of service failure and she did not uphold the complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201302229 – Report issued March 2014
Miss A complained about complications from a spinal block which was performed for the caesarean section delivery of her baby. Miss A developed breathing difficulties and needed a general anaesthetic. Miss A also complained about administrative errors which led to notes of a meeting being addressed to her at a non-existent address, and being sent to her former GP.

The Ombudsman did not uphold the complaint. She found that the spinal block had been administered correctly and that the anaesthetist had treated Miss A's breathing difficulties appropriately before deciding to administer a general anaesthetic. The Health Board had already accepted and apologised for the errors in the distribution of the minutes of the meeting.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201301667 – Report issued March 2014
Ms H complained about her care and management by an Orthopaedic Consultant at the Health Board and about its handling of her complaint. Specifically, she complained that, having been formerly treated for Perthe's disease as a child (characterised by an interruption to the blood supply of the hip joint's femoral head [ball part of the hip joint]; part of the femoral head dies so that ball is unable to rotate feely in the hip socket so restricting movement and risking future arthritis; in extreme cases a hip replacement is required), that investigations (including X-rays) should have been undertaken sooner to diagnose her problems, and alleviate her pain. She had been discharged from orthopaedic care in childhood and first saw the Consultant aged 21. She had lost confidence in the treating Consultant and personally paid for private chiropractor sessions, orthopaedic consultations elsewhere and post surgical physiotherapy. She was found to need urgent bone conservation treatment to avoid a full hip replacement- albeit this could only be performed when she had given birth. Ms H was at the time 26 years old and complained that earlier X-rays and interventions by the Consultant may have resulted in earlier treatment and avoided her pain and financial loss.

The investigation did not uphold the complaints against the Health Board Consultant's care of Ms H. The Ombudsman's professional adviser confirmed that Perthe's disease is still an evolving clinical area and that childhood approaches might now differ from when Ms H was young. Having reached maturity it was still unclear if late interventions could avoid some of the problems associated with Perthe's disease. Only two specialists in the UK undertook the procedure Ms H eventually underwent. The Consultant's approach was not wrong. No earlier X-ray was mandated as they are only warranted where there are clinical reasons for performing them. There were none when Ms H first saw the Consultant aged 21. When she was seen a year later for review an X-ray was performed, showing changes to the hip, and a CT was booked. However the CT had to be cancelled when as Ms H was pregnant. No further investigations or interventions could be conducted until the birth. Ms H then elected to seek a private consultation elsewhere and eventually the hip conservation procedure was performed by a specialist in England (funded by the Health Board).

The Ombudsman found that the care and management of Ms H was within the bounds of acceptable clinical practice, and reasonable; particularly given it was an area of evolving clinical care. She did not uphold the complaint. In relation to complaint handling, the Ombudsman upheld this aspect in part as there were some delays in responding to Ms H albeit the responses provided dealt with the issues reasonably well. A resolution meeting had also been held. The Health Board agreed to the Ombudsman's recommendation to apologise to Ms H for the complaint handling delay.

GP in Aneurin Bevan Health Board area – Clinical treatment outside hospital
Case reference 201300501 – Report issued March 2014

Mr D complained to the Ombudsman that despite several visits to his GP with back pain, the GP failed to examine him, failed to offer him a secondary care referral when treatment was not alleviating his pain and failed to safely monitor his use of Tramadol. It emerged, following a private consultation, that Mr D had severe osteoarthritic changes in both hips.

The Ombudsman did not uphold Mr D's complaint. Her clinical adviser was satisfied that the GP's assessment and treatment of Mr D fell within the boundaries of acceptable clinical practice based on his clinical presentation at the time. She found that the GP was acting reasonably in managing the pain as originating in the back and not conducting a hip examination. She found that managing the back pain conservatively was reasonable and in accordance with the approach advised in the guideline (clinical guideline number 88, Low Back pain: Early management of persistent non-specific low back pain, May 2009), issued by the National Institute for Health and Social Care (NICE). Further, an X-ray and MRI scan showed evidence of lumbosacral deterioration which supported the diagnosis of back pain. Finally, the management of pain with Tramadol was considered appropriate and in line with the approach documented in the NICE guideline. The dosage was also in line with that stated in the British National Formulary, which provides up-to-date references, practical guidance on prescribing, dispensing and administering medicines. The Ombudsman was critical of the standard of record keeping and asked the GP to reflect on this.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201205142 – Report issued February 2014
Miss C complained about the treatment she received for a wrist injury sustained in a fall. She was also concerned about an entry in her medical records which she believed contained an unjustified suggestion that she is mentally ill.

Miss C had longstanding problems with her joints, and had been diagnosed with hypermobility syndrome (a condition where joints are noticeably loose and flexible and may dislocate easily). The Ombudsman found that she had received appropriate treatment for her injury, that the entry made in her records many years ago was reasonable and that, in any event, it had not adversely influenced her treatment. The Ombudsman did not agree with Miss C's interpretation of a more recent entry in her records, and considered that the record which was made would be likely to be to Miss C's benefit. The Ombudsman did not uphold the complaint.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201300819 – Report issued January 2014
Mrs P complained to the Ombudsman about the treatment her late husband received at Llandough and University of Wales hospitals. She complained about a number of issues including that the Health Board unreasonably delayed a procedure to provide him with a percutaneous endoscopic gastrostomy (PEG) tube; that the Health Board did not investigate the cause of his respiratory infection appropriately and that it had concentrated its efforts incorrectly on Motor Neurone disease instead of considering the possibility that he had contracted a tropical disease whilst travelling abroad.

The Ombudsman found that the treatment her husband had received had been appropriate and that the correct investigations, including the possibility of the involvement of tropical diseases as underlying cause had been considered and investigated. Mr P did not receive the PEG for clinical reasons related to his condition at the time he was being assessed for the procedure. Whilst shortcomings in communicating the reasons for postponing the PEG procedure were acknowledged and apologised for by the Health Board, the rationale for doing so was found to be sound. Accordingly the Ombudsman did not uphold the complaint.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201300589 – Report issued January 2014
The investigation considered the adequacy of Mrs X's clinical care in 2011 at the Royal Gwent Hospital, and whether her deterioration could have been avoided. She had been admitted with respiratory problems and sadly died just over two weeks later.

The investigation found that Mrs X was very ill with a number of health problems, many of which had not been apparent before she was admitted to hospital. Therefore the seriousness of her condition and her sad, and relatively sudden, death came as a shock to the family. It was disappointing that her diagnosis and the clinical challenges were not made clearer to family

members who were visiting Mrs X regularly. However, the Ombudsman found that there were no failings in Mrs X's care that would have led to any different outcome. Her medical care was appropriate to her complex condition and the management of her oxygen levels was reasonable, although the family had found her without oxygen on occasions.

While the Ombudsman did not uphold the complaint, the Health Board was notified of issues relating to a failure to obtain a bariatric bed for Mrs X, and staff shortages on the ward.

GP in Betsi Cadwaladr University Health Board area & Betsi Cadwaladr University Health Board – Clinical treatment outside hospital
Case reference 201300387 & 201300391 – Report issued January 2014
Mrs C complained that her late husband, Mr C, was seen by Dr A on 20 April and Dr B on 18 May 2012 with symptoms of chest pain but that the recurrence of his lymphoma was not diagnosed. Mrs C complained that the GPs did not take further action which she said resulted in missed opportunities to make an earlier diagnosis.

Having obtained professional advice, the Ombudsman did not uphold the complaint. The Ombudsman found that the care and treatment provided to Mr C during his consultations was reasonable. In particular, the examination, history and diagnosis reached were appropriate based on Mr C's presenting symptoms and known history at the time. The Ombudsman concluded that the GPs could not reasonably have been expected to have taken any further action during the consultations which could have resulted in an earlier diagnosis of Mr C's recurring lymphoma.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital
Case reference 201203692 – Report issued January 2014
Mrs A complained about the care and treatment her husband received when he attended the A&E Department at Ysbyty Glan Clwyd ("the Hospital") in 2009. In particular she complained that not carrying out a head scan failed to diagnose her husband's subdural haematoma. Mrs A said that her husband should have been prescribed antibiotics to prevent cellulitis. Mrs A further complained that her husband's transfer to the Community Hospital following his surgery was untimely as he was too ill and needed specialist care. Mrs A noted that due to the poor care her husband received he contracted MRSA and Clostridium difficile infections. She was also of the view that not enough was done to keep her husband alive prior to his sad death. Finally, Mrs A said that whilst trying to air these concerns she found it difficult to speak to the relevant consultant as staff were "obstructive".

The Ombudsman's investigation found that the clinical care that Mr A received was reasonable and acceptable within the bounds of clinical practice and therefore did not uphold Mrs A's complaint.

In relation to Mrs A's concerns about poor communication the Ombudsman noted that the Health Board had addressed this aspect of Mrs A's complaint and had apologised to her. The Ombudsman noted that there were numerous documented discussions noted with Mrs A and her husband. The Ombudsman did not consider that further investigation would achieve anything further or result in a different outcome.

The Ombudsman suggested that, if it had not already done so, the Health Board should consider the following:

a) introducing an end of life care pathway/palliative care for dying patients and thereafter considering whether refresher training on end of life care pathways for relevant staff is necessary;
b) demonstrate clear pathways of communication between the patients, their relatives and the appropriate clinician.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201204102 – Report issued January 2014
Mr X complained that the flexible cystoscopy procedure (an investigation performed by inserting a thin, flexible tube into the trethra and up into the bladder), which he underwent at Withybush General Hospital in 2011, was performed "poorly" leaving him in chronic pain and causing him considerable distress. Mr X questioned whether the procedure had been necessary because the urine test undertaken before the procedure did not show the presence of blood. He questioned the sterility of the equipment used for the procedure.

Mr X also complained about inaccurate information contained in the Health Board's written response to his complaint which was contrary to his account. The Health Board had said that he had been suffering from pain and frequency of urine before the procedure, which he said was untrue.

The investigation found that it was appropriate for the investigation, and therefore for the flexible cystoscopy procedure, to be undertaken. There was no evidence that the procedure had been poorly undertaken or that the equipment used had not been properly sterilised.

The Health Board accepted that the information contained in its written response to Mr X had been inaccurate, and it apologised appropriately for that.

The complaint was therefore not upheld.

Opticians in the Cardiff and Vale University Health Board area – Clinical treatment outside hospital
Case reference 201301902 & 201301936 – Report issued January 2014
Mr T complained that the two opticians he saw on consecutive days failed to properly diagnose wet Age Related Macular Degeneration (ARMD – an eye condition that affects part of the retina called the macula and causes problems with central vision; there are two types of ARMD – dry and wet, with the former developing over time and the latter more quickly) and also failed to properly communicate to him the precise nature of the problem in not mentioning the suspicion of dry ARMD. Mr T also complained that the opticians misrepresented what occurred at the consultations, in terms of what examinations were carried out and what discussions were held. Overall, Mr T said that the opticians were to blame for the loss of vision in his right eye.

The Ombudsman found that there was no evidence of the presence of wet ARMD in the records of the two consultations Mr T attended. Whilst the Ombudsman was critical of some poor record-keeping and concluded that further tests might have resulted in a more soundly based diagnosis, the differing recollections of what occurred at the consultations (particularly in respect of whether tests were simply not carried out or if Mr T left before they could be undertaken) could not be reconciled. The Ombudsman therefore concluded that there was no evidence to support Mr T's complaint of a misdiagnosis or a failure to diagnose. Accordingly, the Ombudsman did not uphold the complaint.

Quick fixes & voluntary settlements

Aneurin Bevan Health Board – Complaints Handling (Health)
Case reference 201306196 – March 2014
Mr A complained that the Health Board had referred his complaint about his dental treatment to his dental practice to investigate. Mr A said that the Health Board had not fully explained that it could not consider the complaint once the dental practice had investigated the matter. Mr A said that he did not want this confusion to occur for other complainants in future.

Having considered the information provided, the Ombudsman found that the Health Board's decision to refer Mr A's complaint to the dental practice was not inappropriate. However, the Ombudsman approached the Health Board on the basis that it had not made it entirely clear to Mr A that once the dental practice had responded to the complaint it could not consider it, in accordance with the Welsh Government's complaints handling guidance "Putting Things Right".

The Health Board agreed to include an appropriate paragraph within its acknowledgment letter and/or consent form to ensure that this is made clear to complainants in future cases. The Ombudsman concluded that the action which the Health Board said it would take was reasonable to settle the complaint and closed the file on this basis.

Powys Teaching Health Board – Continuing care
Case reference 201302993 – March 2014
Mr A complained about the way that Powys Teaching LHB ("PTLHB") had considered his claim for retrospective Continuing NHS Healthcare ("CHC") payments. Another Health Board had recommended that Mr A's late father was eligible for retrospective CHC payments to cover the care home fees he had incurred between 14 March 2003 and 6 July 2003. Their recommendation had been considered by the PTLHB at a Panel (in March 2011). This first Panel had concluded however that Mr A's father was not eligible for CHC payments. In response to Mr A's concerns about the decision making process, PTLHB had agreed to reconsider Mr A's claim at a fresh Panel. The second Panel, which met in September 2012, reached the same conclusions as the original Panel. Mr A expressed dissatisfaction with the procedures underpinning the decision.

The Ombudsman's investigation found procedural irregularities. In particular, the same Clinical Adviser had actively participated in the CHC process for both Panels and yet on 15 June 2012, had signed a declaration on a Needs Assessment Document she completed, to say she had had no previous knowledge or involvement with the case prior to carrying out the review. The Needs Assessment Document, which included a recommendation that Mr A's father was not eligible for CHC, had been used at the second Panel.

The PTLHB's agreed to settle the complaint on the following terms:

a) Mr A's case would be reheard by a freshly constituted Panel whose members had not had previous involvement with Mr A's case;
b) that a clinical adviser who had not had any previous involvement in Mr A's case, including a peer review role, would be appointed. The Needs Assessment Document (dated 15 June 2012) would not be used when drawing up another Needs Assessment Document nor would it be presented to the reconstituted Panel. In short, the appointed clinical adviser would look at the matter afresh. Given Mr A's concerns about the process (as outlined in his complaint), consideration would also be given to the feasibility of using a clinical adviser from another health board and in the event this did not occur the reasons would be fully documented on the file;
c) the documentation submitted to the reconstituted Panel would also include the completed Needs Assessment that the previous Health Board's Review Team had submitted to the first Panel on 25 March 2011;
d) in recognition of the distress, inconvenience and time and trouble caused to Mr A as a result of the deficiencies in the process detailed above, PTLHB would, within one month of the final settlement letter, make a payment of £250.00 to Mr A;
e) finally, within one month of the final settlement letter, PTLHB would remind clinical advisers of their obligation to ensure they took reasonable steps to satisfy themselves that they met the requirements of the Declaration in the Needs Assessment Document before signing it.

Hywel Dda Health Board – Complaints Handling (Health)
Case reference 201301405 – March 2014

Mr A complained about his difficulty accessing services at the NHS Dental Practice he usually attended. He was also dissatisfied with the Health Board's response to his concerns about the matter. The Ombudsman contacted the Health Board, which agreed to provide Mr Jones with a more robust response to the concerns that he had raised in accordance with the NHS complaints procedure.

Betsi Cadwaladr University Health Board – Continuing care
Case reference 201304728 – March 2014

Mr J complained about an independent review panel's consideration of his request for a review of a decision that his mother, Mrs J, was not eligible for NHS funded continuing care.

After being approached by the Ombudsman, the Health Board offered to settle the case by convening another Independent Review Panel to consider the matter afresh. The Ombudsman discontinued the investigation on the basis that this was a suitable resolution of Mr J's complaint.

Hywel Dda Health Board – Continuing care
Case reference 201205132 – March 2014

Ms X complained, on behalf of her client, Miss Y, about the Health Board's decision not to offer a payment for the NHS Funded Continuing Care (NHSFCC – a payment by the NHS of care fees for those found to have continuing or complex health care needs) retrospective claim for reimbursement of fees paid for the care of her relative, the late Mr Z, when he was resident at a care home for the period June 2000 to March 2001. The Health Board had been of the view that there was insufficient proof of the payment made to the care home which, it said, made calculating what should be reimbursed impossible, despite the resident being found to be eligible for NHSFCC for the period in question.

While this complaint was being investigated, the Welsh Government issued guidance ("Continuing NHS Health Care (CHC) in Wales: Interim Guidance on Reimbursement for Retrospective Claims processed by Powys Project") which was directly relevant to the disputed issue. The Health Board subsequently agreed to apply the guidance to this case and to reconsider the reimbursement offer for the period in question. As a result, the complaint was resolved and the matter was considered settled.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201306586 – March 2014

The substance of Miss A's complaint related to her treatment and care at the Day Surgery Unit, Royal Gwent Hospital. However, in her letter of complaint to the Ombudsman, she also raised new concerns about the lack of treatment options currently available to her.

In view of Miss A's ongoing concerns, the Health Board agreed to arrange for another clinician to assist with a second opinion in relation to further treatment options that may be clinically appropriate for her.

Abertawe Bro Morgannwg University Health Board & GP in Abertawe Bro Morgannwg University Health Board area – Clinical treatment in hospital
Case references 201305738 & 201306781 – March 2014

Mrs K complained that, while attending an out of hours appointment, with severe stomach pains and unusual bleeding, the GP failed to take a pregnancy test. Mrs K said that one should have been taken. Mrs K says she was told by the out of hours GP that she had IBS and to go home at which time Mrs K asked to see a surgeon. Six hours later she was rushed to theatre, after which she says she was left with no pain relief. Mrs K also complained about the care and treatment received after surgery. Mrs K says no one checked on her blood loss and when she asked for assistance found that she was covered in dried blood.

The Health Board subsequently acknowledged that it had not addressed all of Mrs K's concerns and agreed to reopen the complaint and deal with all outstanding issues.

Abertawe Bro Morgannwg University Health Board & Powys Teaching Health Board – Continuing care
Case reference 201303713 & 201304742 – February 2014

Mrs A's solicitors complained on her behalf about the refusal to reimburse care home fees for the late Mr B. Mr B was assessed as being eligible for NHS Funded Continuing Care from 24 December 1998 to 12 July 1999. The refusal to reimburse the fees was on the basis that the proofs of payment were insufficient. Mrs A's solicitors said that the request for further proofs of payment was unreasonable as, due to the passage of time, none existed.

The investigation considered the information provided by Mrs A's solicitors and Powys Teaching Health Board. Abertawe Bro Morgannwg University Health Board ("ABM UHB") did not provide a formal response. During the course of the investigation, the Welsh Government issued guidance entitled "Interim Guidance on Reimbursement for Retrospective Claims processed by the Powys Project" (the guidance, issued in December 2013). The Ombudsman approached ABM UHB on the basis that its stance appeared unreasonable particularly in light of the guidance. ABM UHB agreed to settle the complaint by dealing with the claim in accordance with the guidance. The Ombudsman felt that this action was reasonable and concluded the investigation against both Health Boards on this basis.

Abertawe Bro Morgannwg University Health Board & Powys Teaching Health Board – Continuing care
Case reference 201304371 & 201304377 – February 2014

Mrs A complained about the refusal to reimburse care home fees for her late mother Mrs B. Mrs B was assessed as being eligible for NHS Funded Continuing Care from 27 January 2003 to 16 February 2004. The refusal to reimburse the fees was on the basis that the proofs of payment were insufficient. Mrs A said that the request for further proofs of payment was unreasonable as, due to the passage of time, none existed.

The investigation considered the information provided by Mrs A and Powys Teaching Health Board. Abertawe Bro Morgannwg University Health Board ("ABM UHB") did not provide a formal response. During the course of the investigation, the Welsh Government issued "Interim Guidance on Reimbursement for Retrospective Claims processed by the Powys Project" (the guidance, issued in December 2013). The Ombudsman approached ABM UHB on the basis that its stance appeared unreasonable particularly in light of the guidance. ABM UHB agreed to settle the complaint by dealing with the claim in accordance with the guidance.

Cardiff and Vale University Health Board – Clinical treatment in hospital
Case reference 201305263 – February 2014

On 3 July 2013, Ms E complained to the Health Board about the care and treatment that she received from Gabalfa Clinic. The Health Board provided its response to the complaint on 28 August 2013, but Ms E remained dissatisfied. In November 2013, Ms E complained to the Ombudsman that the Health Board had failed to respond to her concerns. Having considered the complaint, the Ombudsman was not satisfied that the complaint had been properly addressed, therefore the Health Board were asked to provide a further response. The Health Board did so on 3

December 2013, but Ms E remained dissatisfied on the basis that the further response still failed to respond to all of the concerns raised.

It was suggested that the Health Board arrange a meeting with Ms E to discuss the outstanding concerns relating to maintaining confidentiality of the Emotional Regulation Group (ERG); Concerns about comments made during the ERG; Group composition; and, the lack of contact from Gabalfa Clinic.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201304304 – February 2014
Mrs X complaint is that her late husband did not receive adequate care and treatment whilst in hospital.

After considering Mrs X's complaint, it was understood that the Health Board carried out an investigation following the death of her husband and some failings were identified. However, the Health Board had not offered an apology. Following contact from the Ombudsman's office, the Health Board agreed to provide Mrs X with an apology for the failings identified.

GP in Betsi Cadwaladr University Health Board area – Clinical treatment outside hospital
Case reference 201305639 – February 2014
The complainant was unhappy that the GP refused to treat his father at home after a telephone conversation about his condition, which then resulted in an unnecessary trip to A&E. The complainant was also unhappy that his initial concerns to the Surgery were not passed to the GP as requested.

It appeared that the Surgery had not had the opportunity to consider and respond to the issues raised with the Ombudsman. Therefore, the letter of complaint was forwarded to the Surgery and it was asked to respond in detail.

Aneurin Bevan Health Board – Clinical treatment in hospital
Case reference 201304027 – February 2014
The complainant was unhappy that the Health Board had not fully considered his complaint and, because he had sought legal advice, he had subsequently been advised that he could not complete the 'Putting Things Right' (PTR) complaint process.

Following contact from the Ombudsman's office, the Health Baord agreed to complete the complaint investigation through the PTR process.

Betsi Cadwaladr University Health Board & Powys Teaching Health Board – Continuing care
Case reference 201303838 & 201304743 – January 2014
Mr A's solicitors complained on his behalf about the refusal to reimburse care home fees for the late Mrs B. Mrs B was assessed as being eligible for NHS Funded Continuing Care from 1 November

1997 to 30 October 1998 and from 22 December 1999 to 10 January 2000. The refusal to reimburse the fees for the entire eligibility period was on the basis that the proofs of payment were insufficient. Mr A's solicitors said that the request for further proofs of payment was unreasonable as, due to the passage of time, none existed.

After the Ombudsman commenced the investigations, Betsi Cadwaladr University Health Board made an offer of payment to Mr A. This was accepted by Mr A.

Aneurin Bevan Health Board & Powys Teaching Health Board – Continuing care
Case reference 201304079 & 201304744 – January 2014
Mr A's solicitors complained on his behalf about the refusal to reimburse care home fees for the late Mrs B. Mrs B was assessed as being eligible for NHS Funded Continuing Care from 1 April 1999 to 26 December 2002. The refusal to reimburse the fees was on the basis that the proofs of payment were insufficient. Mr A's solicitors said that the request for further proofs of payment was unreasonable as, due to the passage of time, none existed.

The investigation considered the information provided by Mr A's solicitors, Aneurin Bevan Health Board and Powys Teaching Health Board (the Health Boards). During the course of the investigation, the Welsh Government issued "Interim Guidance on Reimbursement for Retrospective Claims processed by the Powys Project" (the guidance, issued in December 2013). The Ombudsman approached Aneurin Bevan Health Board on the basis that its stance appeared unreasonable, particularly in light of the guidance. Aneurin Bevan Health Board agreed to settle the complaint by dealing with the claim in accordance with the guidance.

Hywel Dda Health Board – Continuing care
Case reference 201304143 – January 2014
A solicitor complained that, after concluding Mrs V's care needs did not meet the criteria for Continuing NHS Health Care funding, the Health Board incorrectly considered the four key indicators (nature, intensity, complexity and unpredictability). The solicitor also complained that the Health Board:

- considered an incorrect definition of intensity and of complexity;
- should not have considered the nursing home's ability to manage Mrs V's needs;
- misinterpreted Mrs V's needs relating to her nutrition and altered states of consciousness; and,
- failed to recognise that her cognitive impairment was an intense health need and that Mrs V had an intense health need in relation to her mobility and a number of complex health needs including those relative to her skin and mobility.

The Health Board accepted the Ombudsman's suggestion that it hold an Independent Review Panel. Consequently, the investigation was discontinued.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201303745 – January 2014

Mrs F complained that she had been in pain since a right hip replacement operation in 1999 and that despite numerous consultations and interventions, no diagnosis of the cause of her hip pain was made until 2011 when loosening of the right hip was identified. This was corrected by surgery which alleviated Mrs F's pain. Mrs F could not understand how this was not diagnosed sooner. Had it been recognised, it could have been corrected at a much earlier stage and saved Mrs F years of pain and mobility difficulties. The Health Board, in its response to her complaint, stated that there had been no evidence that the hip joint had loosened prior to 2011.

The Ombudsman sought clinical advice on Mrs F's complaint. The adviser noted that this was a complex case. He found no evidence from the records to indicate that anything went wrong with the initial hip replacement operation and all reasonable investigations into the cause of Mrs F's pain were done. All bone scans and x-rays prior to 2007 showed no signs of infection or loosening in the hip joint.

However, an x-ray in 2007 indicated loosening of the hip joint and this was missed by the treating team. In addition, an x-ray in 2010 showed loosening of the hip joint and change in orientation of the cup but this was wrongly reported. The adviser concluded that there was evidence of loosening of the hip joint from 2007 onwards but this was not followed up. This represented substandard care.

The Health Board accepted the adviser's findings and, on that basis, agreed to contact Mrs F to arrange redress in the form of an apology and financial compensation for the additional time that Mrs F was in pain.

Abertawe Bro Morgannwg University Health Board – Continuing care
Case reference 201204465 – January 2014

Ms X complained, on behalf of her client, Mr Y, about the Health Board's decision not to process the NHS Funded Continuing Care (NHSFCC) retrospective claim for reimbursement of fees paid for the care of his mother, Mrs Y (dec.), when she was a resident at a care home for the period 1996 - 1999. The Health Board had originally refused the request for a review because it had been of the view that the claimant had provided insufficient proof that Mrs Y's fees had been paid by her or her family.

While this complaint was being investigated, the Health Board decided, because of recent guidance issued by the Welsh Government relating to the issue of reimbursement for retrospective NHSFCC claims, to allow the claim to proceed and for the case to be reviewed for NHSFCC eligibility. As a result, the complaint was resolved and the matter was deemed to have been settled.

Cardiff and Vale University Health Board – Continuing care
Case reference 201304919 – January 2014
Mr G's solicitors complained about the Health Board's consideration of a retrospective application for funding for the care home fees of Mr G's late mother. Mr G's solicitors said that the Health Board had failed to act in accordance with procedure, had not taken into account all relevant information in reaching a decision on eligibility and had unreasonably declined to refer the case to an independent panel.

The Ombudsman contacted the Health Board to commence an investigation, but asked if a settlement might be reached in the alternative. In response, the Health Board agreed to reconsider the case, taking into account all of the concerns raised by Mr G's solicitors, and to issue a fresh decision, ensuring that comprehensive reasoning was provided. The Ombudsman considered this to be a fair resolution. The Ombudsman therefore discontinued her investigation on the basis of this voluntary settlement.

Hywel Dda Health Board – Clinical treatment in hospital
Case reference 201305494 – January 2014
The main aspect of Ms X's complaint was regarding the care and treatment her late mother received during her admission to Withybush General Hospital in November 2011 and January 2012. Ms X raised these concerns with the Health Board in a letter of complaint via the Community Health Council on 22 January 2013. However, although Ms X received a number of holding letters, she was yet to receive a final response from the Health Board.

The Ombudsman's office contacted the Health Board, which acknowledged the delay in providing Ms X with a final response. It also agreed to apologise for the prolonged delay and to provide Ms X with a final written response by an agreed date.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital
Case reference 201305605 – January 2014
Mrs N complained that, since being moved to Ward X in Morriston Hospital, her sister had not had access to specialist equipment which was part of her treatment. Mrs N also felt that her sister should be a on a specialist neurological unit. Mrs N was yet to receive a final response from the Heath Board.

Following contact from the Ombudsman's office, the Health Board agreed to provide Mrs N with a final response by a specified date.

Dentist in Hywel Dda Health Board area – Clinical treatment outside hospital
Case reference 201305031 – January 2014
Miss X complained that despite attending her dentist complaining of various uncomfortable and painful symptoms to her mouth, her dentist failed to take an x-ray, provide any medication and diagnose an infection.

Following contact from the Ombudsman's office, the Dental Centre agreed to re-consider the complaint and provide a full response to Miss X.

Dentist in Abertawe Bro Morgannwg University Health Board area – Clinical treatment outside hospital
Case reference 201305182 – January 2014
Ms X complained that the Dental Centre carried out various work on her teeth which worsened her symptoms, causing her to have a weekend stay in hospital. Having sought a second opinion, it appeared that the work carried out by the Dental Centre was not adequate. Ms X therefore requested a full refund in order to pay to rectify the problem.

The Dental Centre confirmed they had received dental records of the dentist who provided a second opinion, and have agreed to look into the complaint.

GP in Aneurin Bevan Health Board area – Clinical treatment outside hospital
Case reference 201303881 – January 2014
Mr A complained that the practice changed a diagnostic tool and that the new tool makes it difficult for him to manage his condition.

The practice agreed to assess Mr A to establish whether he can be excluded from the change, in view of section 4G of the Standard Operating Procedures, which states that 'Any patient who contacts either the practice or the LHB with a valid reason as to why their test strips should not be changed', should be excluded from the change.

Abertawe Bro Morgannwg University Health Board – Non-medical services
Case reference 201302174 – January 2014
Mrs X complained about the care and treatment her husband received whilst he was a patient in Morriston Hospital. Mrs X also complained about Abertawe Bro Morgannwg University Health Board's ("the Health Board") response to her complaint, specifically the delays in responding.

Having reviewed the complaint, the Ombudsman concluded that the clinical concerns raised by Mrs X had been adequately addressed by the Health Board in its complaint response. However there were concerns about the delays in responding to Mrs X's complaint and the Health Board's failure to provide her with information on the escalation of complaints.

With respect to the complaint handling, the Health Board was contacted and it agreed to the following action in settlement of the complaint:
a) apologise for the delays in dealing with Mrs X's complaint and provide an explanation, where available, for the delay;
b) apologise for the failure to provide Mrs X with information relating to the escalation of complaints;
c) pay Mrs X £250 in recognition of the distress, time and trouble that she was put to in trying to resolve her complaint.

Abertawe Bro Morgannwg University Health Board – Appointments/ admissions/ discharge/transfer procedures
Case reference 201305576 – January 2014
Ms A complained about aspects of the care of her late father by the cardiology department at Morriston hospital. Ms A had made a complaint to the Health Board, and had received a response. She subsequently raised a number of further concerns and complaints with the Ombudsman.

The Ombudsman considered that the Health Board could usefully directly address Ms A's additional concerns, although it remained open to Ms A to come back to the Ombudsman when the Health Board had done so. The Health Board agreed to investigate and respond to the further matters within four weeks.

Betsi Cadwaladr University Health Board – Complaints Handling
Case reference 201305087 – January 2014
Mr X complained that the Health Board failed to respond in full to his original complaint and disregarded his subsequent e-mails and phone calls.

Following contact from the Ombudsman's office, the Health Board agreed to contact Mr X to offer a meeting to discuss the outstanding concerns.

Benefits Administration

Upheld

Ceredigion County Council – Council Tax Benefit
Case reference 201204992 – Report issued February 2014
Mrs A complained that an overpayment (whereby the Council has paid a higher amount of benefit than the claimant is entitled to) was raised on her Housing Benefit (HB) and Council Tax Benefit (CTB) account and she was interviewed under caution for suspected fraud because the Council said she failed to inform it of an increase in her Child Tax Credits which would affect her benefit. Mrs A also complained about way her case had been handled and the complaint was not dealt with adequately.

The Ombudsman found that there had not been an increase in Mrs A's Child Tax Credits, and that the Council had been calculating her benefit using the wrong figure. The Council did not fully investigate the fraud allegation and did not advise her of the outcome of the investigation for ten months. The Council also did not respond to correspondence from Mrs A; did not recognise an appeal; and, did not follow the Regulations and guidance for raising an overpayment or establishing whether Mrs A had an underlying entitlement to benefit.

The Ombudsman made a number of recommendations, including that the Council apologise and make a number of redress payments to the complainant in respect of the failure to conduct a full review as well as in recognition of the time and trouble in making the complaint. The Council agreed to implement these recommendations.

Community Facilities, Recreation and Leisure

Quick fixes & voluntary settlements

Llannon Community Council – Cemeteries/graves/headstones
Case reference 201306290 & 201304492 – March 2014
Mrs Y complained about issues relating to changes to the registration of her parents' grave by Llannon Community Council. There also appeared to be a discrepancy over the numbering of the grave.

The Ombudsman proposed that the Council apologise to Mrs Y for the incorrect handling of previous transfers of ownership, and provide a fuller explanation regarding grave numbers. The Council agreed to take these steps and the Ombudsman considered this reasonable to address and resolve Mrs Y's outstanding concerns.

Education

Quick fixes & voluntary settlements

Cwm Taf Health Board – Special Educational Needs
Case reference 201303731 – March 2014

Mr & Mrs A complained about the Health Board's decision to impose sanctions against them following incidents of alleged verbal aggression towards Health Board staff at meetings to consider their son's special educational needs provision. Mr & Mrs A said that the sanctions made it impossible for them to represent their son's interests. As a consequence they had withdrawn their consent for the Health Board to undertake any further assessment of their son's needs and he had been without therapy for a number or months.

The Ombudsman identified a number of administrative failings in relation to the provision of assessment reports, the application of its Code of Conduct and complaint handling. The Ombudsman contacted the Health Board with a view to reaching an early resolution of the complaint. The Health Board agreed to:

a) apologise to Mr & Mrs A for the administrative failings identified;
b) attend independent dispute resolution with Mr & Mrs A;
c) in the event that Mr & Mrs A disagree with the professional opinion of the Health Board's therapist, offer a second independent NHS opinion;
d) make arrangements for any missing hours of therapy to be provided;
e) undertake a review of the terms of its Service Level Agreement with the Council;
f) process Mr & Mrs A's information request in accordance with the provisions of the Freedom of Information Act 2000.

Rhondda Cynon Taf County Borough Council – Special Educational Needs
Case reference 201304316 – March 2014

Mr & Mrs A complained about the Council's failure to ensure compliance with their son's Statement of Special Educational Needs in respect of requirement to provide 45 minutes per week of speech and language therapy.

The Ombudsman found that Mr & Mrs A had been involved in a dispute with the Council's chosen service provider, Cwm Taf Local Health Board. As a consequence they had withdrawn their consent for an assessment of their son's therapy needs to be undertaken by the Health Board. The Council's Service Level Agreement with the Health Board failed to clarify when a joint response to such matters was required resulting in missed opportunities for an earlier resolution of the dispute. The Ombudsman contacted the Council with a view to reaching an early resolution of the complaint.

The Council agreed to:

a) apologise to Mr & Mrs A for the weaknesses in its Service Level Agreement with the Health Board;
b) repeat the offer of independent dispute resolution to be attended by all parties;

c) in the event that Mr & Mrs A disagree with the professional opinion of the Health Board's therapist, offer a second independent NHS opinion;
d) make arrangements for any missing hours of therapy to be provided;
e) undertake a review of the terms of the Service Level Agreement with the Health Board.

Ceredigion County Council – School Transport
Case reference 201300587 - February 2014
Miss P complained that the Council refused to provide free school transport to her son, other than to the school it considered to be the nearest suitable school in her catchment area. She did not consider that the Council's choice of nearest suitable school would meet her son's additional learning needs as identified in a privately commissioned educational psychologist report. She considered that the school he attended was the nearest suitable school that could meet his needs and that transport should be provided free of charge.

During the investigation it was identified that the Council had failed to inform Miss P of her right to appeal the decision on school transport funding to the Council's Transport Appeal Panel ("the Panel") and that its published procedures about school transport did not contain information about this right of appeal. In light of the foregoing, the Ombudsman felt that there was scope to settle the complaint.

In response to the Ombudsman's approach, the Council agreed to take the following action to settle the complaint:

a) the Chief Executive would apologise in writing to Miss P for the Council's administrative failings identified during the investigation. In addition, the Council would pay her the sum of £100 for the time and trouble taken to pursue her complaint;
b) the Council would write to Miss P to provide her with a more detailed analysis and explanation on how it reached the decision on the nearest suitable school;
c) the Council would write to Miss P to arrange a suitable date to convene the appeal panel;
d) the Council would ensure that the appeal procedure is formalised and published in line with the requirement set out in The Learner Travel Information (Wales) Regulations 2009 and would ensure that this information is contained on the relevant pages of its website relating to school transport and forms part of the standard information provided to parents;
e) the Council would remind staff of the importance of full and accurate records of all decisions taken.

Environment and Environmental Health

Quick fixes & voluntary settlements

The City and County of Swansea – Other
Case reference 201306647 – March 2014
Ms A complained that there were number of issues with her neighbour in relation to anti-social behaviour, specifically regarding rubbish being piled in the garden and the neighbour damaging property. Ms A says that the Council had not taken any action.

Whilst the Council stated that it had not had any contact from Ms A since 2012, in light of the concerns raised, it would contact Ms A to arrange a meeting to discuss her complaint.

Finance and Taxation

Quick fixes & voluntary settlements

Bridgend County Borough Council – Finance and Taxation
Case reference 201305900 – February 2014
Mr X complained that the Council sent him a National Non-Domestic Rates Demand Notice for the period of 1 April 2013 to 31 March 2014 with a nil balance, and had since provided him with a further notice advising that there was a fee payable for that same period.

Mr X was provided a six month exemption period, after which the full fees were payable. However, in view of the period of time taken by the Council to respond to Mr X's e-mails, the Council agreed to pay Mr X £100 for time and trouble in pursuing the matter.

Bridgend County Borough Council – Finance and Taxation
Case reference 201306195 – February 2014
The complainant was unhappy that the Council was pursuing a debt from benefits, used to fund care, despite the Council being aware of the housing circumstances. The complainant stated they were given incorrect advice about the complaints procedure, resulting in them not raising a formal complaint with the Council. In view of the complainant's current circumstances, the Council agreed not to pursue the debt.

Housing

Upheld

Cardiff Council – Other
Case reference 201204993 – January 2014
Mr J complained that the Council had taken no action/timely action against tenant neighbours about whose anti-social behaviour (ASB) he had complained repeatedly - both to the Council and the Police. Specifically, Mr J complained that the Council had delayed in / failed to: promptly investigate his concerns, issue proceedings against those tenants, and have regard to his and his children's human rights and dignity. Mr J said that his young son attempted to take his life because of events. Mr J's complaints also included that the Council had wrongly demanded from him Housing Benefit (HB) overpayments, and had not supported / communicated with him effectively when he was later a witness in its legal proceedings against the tenants. He added that he had been put to significant expense and the family as a whole suffered great distress including having to flee the property to temporary accommodation.

The Council agreed early on that it had wrongly requested a HB overpayment from Mr J and that recording within its ASB team was poor. Evidence from the Ombudsman's investigation supported those findings. The ASB team had largely relied on the Police to take action, as opposed to properly investigating itself and following good ASB practice, which might have resulted in action sooner. However, decisions regarding legal action were for the Council to take and it was not for the Ombudsman to decide whether human rights were infringed or not. That said, Mr J's complaints were mostly upheld; there were significant failings resulting in great injustice to Mr J and his family – medical evidence supported a possible (albeit not absolute) link between events and his son's actions.

The Council agreed to the following recommendations:

a) an apology to Mr J and his family and redress of £3000;
b) staff training on the identified relevant HB regulation;
c) a Senior Officer to remind the ASB team about documentation and the recording of conversations/actions/ and reasons for decisions taken and the Legal team to provide training to the ASB team on matters of evidence;
d) the preparation of an information sheet for those who are to be witnesses in support of the Council's legal proceedings with a named contact for their duration.

Quick fixes & voluntary settlements

Tai Calon – Repairs and maintenance
Case reference 201306672 – March 2014
Mrs X stated that, since she had been working with Mr Y, they had been trying to resolve an ongoing problem with damp in Mr Y's living room. Due to the lack of progression and communication from the Housing Association, they requested that the Ombudsman look into the complaint.

Following contact from the Ombudsman's office, the Housing Association advised it wanted all of the external works to be completed on a number of its properties before it started on the internal works, and that such works should commence shortly. The Housing Association agreed that an officer would contact Mr Y to discuss a date for these works to be completed.

Cartrefi Cymunedol Gwynedd – Repairs and maintenance
Case reference 201306293 – March 2014

Mr R complained about Cartrefi Cymunedol Gwynedd's ("CCG") response to his complaints. One element of Mr R's complaint related to his perceived lack of communication between the organisation and contractors employed to carry out various works on his property. In addition Mr R complained about that an electric cable loosened to allow the contractors to complete works at his property was not reinstated to its original condition after the completion of the works.

Following consideration of the complaint the investigator noted that CCG had responded to the majority of the issues raised. However, the issue relating to the other contractors was not specifically investigated and addressed by CCG, as only a brief reference was made to it in the original letter of complaint.

The investigator contacted CCG who advised that it had contacted the electricity supplier and that the cable would be reinstated in the forthcoming week. In addition CCG agreed to investigate the issue and provide a written response to Mr R within twenty working days.

Cartrefi Cymunedol Gwynedd – Complaints Handling (Housing)
Case reference 201302899 – February 2014

Mrs T complained that her landlord, Cartrefi Cymunedol Gwynedd (CCG), had refused to agree to an adaptation request for a downstairs toilet which she needed in light of her medical condition. She complained that at its first panel hearing her request had been refused for an incorrect reason, albeit CCG had recognised this, apologised, and reconvened a second panel. The second panel had declined to carry out the adaptation of a wheelchair accessible walk-in shower and toilet facility downstairs saying it was not practically possible within the confines of the property. Mrs T argued that she only needed the toilet and that it was unfair that CCG would not provide this to meet her current medical and disability needs.

The investigation considered Mrs T's complaint and the documentary evidence including the OT assessment upon which the second panel had based its decision. The OT assessment clearly identified that Mrs T's future needs would only be met by the adaptation recommended. The Ombudsman felt it was not unreasonable therefore for CCG to place weight upon that in reaching its decision. Nevertheless, in light of Mrs T's immediate needs, CCG was asked whether it might consider taking immediate action to assist Mrs T. It agreed to install the downstairs toilet she had requested. On that basis, the Ombudsman considered this a reasonable settlement of Mrs T's complaint, and she agreed. The work was completed and the investigation was discontinued on this basis.

Coastal Housing Group Ltd – Neighbour disputes and anti-social behaviour
Case reference 201304769 – February 2014

Mrs Z complained that the noise pollution emanating from a neighbouring property had affected the peaceful enjoyment of her home. Following contact from the Ombudsman's office, and after conducting an investigation into the situation, Coastal Housing Group Ltd agreed to install soundproofing to the neighbouring property to alleviate the problem.

Cartrefi Cymunedol Gwynedd – Repairs and maintenance
Case reference 201304514 – February 2014

Mr & Mrs B complained about improvements works at their home undertaken by their landlord, Cartrefi Cymunedol Gwynedd ("CCG"), over December 2012 and January 2013. Mr & Mrs B were concerned about unreasonable delays in completing work to their bathroom during which time they were without bathing facilities. They also said that CCG had failed to provide them with adequate support to restore the decorative order of their home.

On receipt of the complaint, the Ombudsman contacted CCG and it agreed to undertake the following in settlement of the complaint:

- in recognition of the delay completing the works to the bathroom and the resulting disruption, pay to Mr & Mrs B the sum of £500;
- support Mr & Mrs B in obtaining materials and in arranging for reasonable re-decoration work to their home;
- identify ways to provide assistance to vulnerable tenants who may need to re-decorate following improvement work;
- review its Redecoration Policy;
- put in place a procedure for identifying vulnerable tenants who might require additional support to maintain their homes and tenancies.

Cartrefi Cymunedol Gwynedd – Other
Case reference 201302448 – February 2014

Mr X complained that Cartrefi Cymunedol Gwynedd (CCG) failed to keep him informed of works being carried out on neighbouring properties. Also contractors blocked access to his car which, as a registered disabled wheelchair user, meant he relied on his wife to repeatedly ask contractors to move their vehicles. CCG apologised for these points but refused Mr X's request for compensation.

Following contact from the Ombudsman's office, CCG agreed to pay £250 in view of the time and trouble Mr X had encountered in pursuing his complaint.

Cardiff Council – Repairs and Maintenance
Case reference 201305898 – February 2014

Mr B complained that Cardiff Council agreed to inspect his block in October 2013, and then commence fitting non slip flooring in the communal areas within the following six weeks. However, four months later, there had been no sign of these improvements.

Following contact from the Ombudsman's office, the Council agreed to bring forward the improvements on this block and the adjacent blocks.

Wrexham County Borough Council – Repairs and maintenance
Case reference 201302813 – February 2014

Ms P complained that the Council had overcharged her for repairs and redecoration of accommodation she occupied with her family between 13 June 2000 and 20 October 2011. She had received a response to her original complaint in 2012, but, had not received a reply to a further letter sent by Shelter Cymru on her behalf in May 2013.

The Ombudsman contacted the Council, which agreed to review the complaint and reply directly to the complainant.

Grwp Gwalia Cyf Ltd – Repairs and maintenance
Case reference 201305316 – January 2014

Mr X complained that, having made a number of telephone calls to the Housing Association regarding a faulty boiler, and having an engineer attend his property on a number of occasions, the faulty boiler was never adequately repaired. This led to a formal complaint being raised to the Housing Association.

Following contact from the Ombudsman's office, the Housing Association advised that, in order to resolve the complaint and problems with the faulty boiler, it had agreed to replace the old boiler with a new one. The Housing Association was in the process of arranging an engineer to attend the property to carry out the installation of the new boiler.

Grwp Gwalia Cyf Ltd – Other
Case reference 201305696 – January 2014

The Housing Association would not repair a stair-lift as the complainant did not have a maintenance contract. The complainant said this option had not been offered and they were unable to get up stairs without the stair-lift.

The Housing Association agreed to repair the stair-lift while the tenant awaited reassessment of the suitability of the property. It also said that it would arrange a maintenance contract with the tenant.

Coastal Housing Group Ltd – Complaints Handling
Case reference 201304681 – January 2014

Mrs Q is a tenant of CHG. She complained to CHG about its handling of a matter relating to a high hedge between her and her neighbour's property. She subsequently complained to the Ombudsman's office about CHG's actions and that it had not responded fully to her complaints.

Following contact from the Ombudsman's office, CHG agreed to provide comprehensive written responses to Mrs Q's concerns and complaints, issued by a senior officer. The Ombudsman considered this to be a reasonable course of action.

Planning and Building Control

Upheld

Monmouthshire County Council – Handling of planning application
Case reference 201303444 – Report issued March 2014
Ms B and Mr S complained about the actions of Monmouthshire County Council in relation to a boundary wall that their neighbour had erected between their two properties. They were concerned about the original planning permission and the Council's approach to planning enforcement once the neighbour failed to face both sides of the wall in stone. They were also dissatisfied with how the Council dealt with their complaints.

The Ombudsman found that while the time it had taken for the wall to be completed was very unfortunate, the actions of the Council were largely appropriate. The Council had served an enforcement notice once it became apparent that the neighbour had failed to complete the wall, and that enforcement notice was upheld at appeal. Unfortunately matters were delayed due to the need for Ms B and Mr S and the neighbour to agree terms for him to access their land to complete the work. The Ombudsman did not uphold the complaint about the planning matters.

The Ombudsman found that there were some failings in the way Ms B and Mr S's complaint was dealt with by the Council. In particular, it took too long and the response did not address their proposal to resolve the matter. The Ombudsman upheld the complaint about the way the Council dealt with Ms B and Mr S's complaint to the extent of the failings identified. She recommended that the Council provide them with a formal written apology.

Not Upheld

Isle of Anglesey County Council – Handling of planning application
Case reference 201203899 – Report issued February 2014
Councillor A complained, on behalf of a local action group, about the grant of planning permission for a large-scale marina development. The complaint alleged:

- that the Council failed to adequately publicise the proposals, or to engage with the public over the significant development;
- that consideration of the application did not take sufficient account of policy documents and plans;
- that insufficient consideration was given to the impact of the proposed development on the conservation area and the environment.

The Ombudsman took advice on the complaint from an experienced planning consultant. The Ombudsman identified failings in the officer's report to the Planning Committee of the Council, and was critical of the interpretation which the Council had put on a letter from the Welsh Government. However, she was content that the report was on the whole adequate and fair, and that the errors and failings which she identified were not material to the decision to grant permission for the development. Nevertheless, she asked the Council to reflect on her report with a view to avoiding such failings in the future.

Carmarthenshire County Council – Building Control
Case reference 201203746 – Report issued January 2014
Mr X complained, on behalf of Company Y, that the Council was incorrectly implementing building control legislation to frustrate the company's legitimate practices. He complained that those failings were having a serious impact on the company's professional reputation and income. He specifically complained about improper marketing on the part of the Council; the improper use of building control legislation in relation to concerns raised about the adequacy of structural alterations at a church; and the inappropriate attendance of Council officers at a site where Company Y was undertaking the building control function.

The investigation found that there was no evidence of unfair practice in the way that the Council undertook its marketing exercises when writing to Company Y's clients. With respect to the church, the investigation found that the Council, when a concern was reported to it by a member of the public, had not acted unreasonably by inspecting the defective and potentially dangerous structure, and by asking for that inadequacy to be remedied. Regarding the third issue, the investigation found that it was not unreasonable for the Council, in these particular circumstances, to have visited the site and to have undertaken an inspection given that Company Y had applied for an extension of time so that outstanding works could be completed, when those works were not specified and when the building in question had, to the Council's knowledge, already been occupied. There had also been some doubt as to whether the notice which gave the company authority to supervise the works remained valid because of when the application for the extension was made. The complaint was therefore not upheld.

Quick fixes and Voluntary settlements

Conwy County Borough Council – Tree management/TPOs/High Hedges
Case reference 201204936 – March 2014
Mr W's complaint related to trees which are owned by the Council, and situated at the rear of his property. Mr W complained that the branches overhung his fence line and could potentially cause damage to his fencing. Also, that the trees shed a substantial fall of leaves and other debris, following which he had no choice, but to carry out additional maintenance to his garden. Mr W complained that whilst the Council had previously agreed to remove the overhanging branches, these works had not materialised.

Upon receiving the complaint, the Investigating Officer contacted the Council for its comments on the complaint. The Council explained that the trees in question are protected by a Tree Preservation Order, therefore works to these trees are restricted, unless an application is made to the Council's Regulatory Services Department. However, the Council explained that it had pruned the overhanging branch and it would carry out other works to tidy up the woodland.

The Investigating Officer was satisfied that the action which the Council had said it had taken was reasonable and would resolve the complaint.

Roads and Transport

Quick fixes and Voluntary settlements

Blaenau Gwent County Borough Council – Other
Case reference 201306042 – February 2014
Mr B complained that his application for a Blue Badge had been refused. Although he had been told that he did not meet the criteria, he could not understand why this was as his doctor had supported his application.

The Council agreed to write to Mr B setting out the criteria which it had applied and explaining why he did not meet them. The Ombudsman considered that this action was reasonable and would resolve the complaint.

Social Services - Adult

Upheld

Rhondda Cynon Taf County Borough Council – Services for people with a disability
Case reference 201204692 – January 2014
Mr K had a health condition which affected his mobility and ability to undertake many tasks. He made a number of complaints about Rhondda Cynon Taf County Borough Council (the Council).

The Ombudsman upheld a complaint that the Council mis-advised Mr & Mrs K that they could not apply for a Disabled Facilities Grant in privately rented accommodation. The Council acknowledged that an officer had incorrectly advised Mr & Mrs K about this.

The Ombudsman upheld a complaint that the Council failed to undertake a community care assessment and an adequate carer's assessment. The Ombudsman noted that while the social worker undertook a community care assessment in January 2011, no decision was forthcoming throughout 2011 and into 2012 about Mr K's eligibility for services. There was no care plan, and it was not clear whether the case was open or closed.

The Ombudsman found that there had been some delay in acquiring "proof" of Mr K's disability. Further, the social worker and occupational therapist could have liaised more effectively about Mr K's medical condition.

The Ombudsman considered a complaint that the Council refused to provide emergency care for Mr K when Mrs K was admitted to hospital. The Council acknowledged that it should have formalised its risk assessment, and the Ombudsman concluded that staff could have worked more effectively with the family to identify risks and potential solutions.

The Council agreed to implement the following recommendations:

- to apologise to Mr & Mrs K for the failings identified;
- to pay Mr & Mrs K £500 for the distress and uncertainty caused by the Council in failing to conclude the assessment process and for delays in obtaining medical opinion, £250 for their time and trouble in pursuing this complaint, and £76 for the cost of the hotel on 2 March 2012;
- to arrange for Mrs K to complete a carer's assessment, if she wished to do so, with appropriate support;
- to ensure that it has a mechanism for managers to review open cases to check that cases are being actively managed and are not allowed to drift;
- to ensure that the disability team's skills and knowledge are up to date with regard to (i) the meaning and impact of the Equality Act in relation to those with fluctuating medical conditions, and (ii) the assessment of service users who have fluctuating medical conditions especially those with both physical and psychological dimensions;
- to consider how it can be clear with potential service users how decisions about assessment, eligibility and provision are taken, and that there is not always an automatic right to provision.

Quick fixes & Voluntary settlements

Gwynedd Council – Other
Case reference 201303095 – March 2014
Mr A's representative complained that the Council had failed to implement recommendations made following an independent stage 2 investigation of Mr A's complaint. Ten months had elapsed since the stage 2 complaint investigation findings and six months since the Council had stated in writing that it would be making an offer of financial compensation to Mr A that week.

Following enquiries from the Ombudsman's office, the Council subsequently took the following action to settle the complaint and progress matters, namely:

1) it made an offer of financial compensation to Mr A;
2) it confirmed that it would take into account, in any negotiation about reasonable legal costs, the period of delay between March and December 2013, when no offer had been forthcoming;
3) the Council had notified other relevant parties about its offer to Mr A.

Wrexham County Borough Council – Services for vulnerable adults
Case reference 201304822 – January 2014
Mr A complained about the investigations that were carried out in relation to his concerns about the potential abuse and/or neglect of his late father at a care home within the Council's locality.

Having considered the information provided on behalf of the complainant and relevant guidance on this matter, the Ombudsman approached the Council on the basis that its decision not to carry out a new investigation of Mr A's concerns in accordance with Section 11 of the Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (first issued in November 2010) appeared unreasonable. The Council agreed to settle the complaint by undertaking a new investigation of Mr A's concerns in accordance with the interim guidance.

The Ombudsman concluded that the action which the Council said it would take was reasonable to settle the complaint and closed the file on this basis.

Social Services - Children

Upheld

Carmarthenshire County Council – Other
Case reference 201300713 – March 2014
Mr Y complained to the Ombudsman that the Council (in its social services function) had carried out inappropriate disclosure visits with the Police (in respect of a child sex offence) to his friends. Mr Y was concerned about the tone and content of the meetings which took place. He also complained that subsequently the Council did not investigate his complaint in a satisfactory manner.

In investigating the complaint the Ombudsman took advice from one of her Professional Advisers on social services matters.

Taking account of this the Ombudsman was of the view that it was appropriate for the Council to carry out the visits as this was the first time that this body had become aware of Mr Y's background circumstances and the nature of his involvement with the families concerned. The Ombudsman said that the Council adhered to its child protection procedures and did not uphold this element of the complaint. She did however raise some shortcomings.

Mr Y complained about the nature and duration of the visits to his friends. The Ombudsman found nothing in the written records that suggested that the interviews were threatening or that judgemental language had been used. She was however unable to make any further determination on this element of Mr Y's complaint.

The Ombudsman upheld the complaint made by Mr Y about the Council's complaint handling. The Ombudsman did note that the circumstances surrounding Mr Y's complaint were unusual. She accepted that in this context it was reasonable for the first response to be by way of an explanatory letter. The Ombudsman noted that the subsequent investigation carried out under Stage 1 of the Council's Complaints Procedure was not wholly unsatisfactory although she highlighted some shortcomings.

The Ombudsman was however most concerned about the Stage 2 process. The Council refused for Mr Y's complaint to be considered at Stage 2 which was not in line with the Council's Procedure or the expectation created for Mr Y. As a consequence of this the Ombudsman was of the view that there had been maladministration.

The Ombudsman recommended that the Council should:

a) apologise to Mr Y for the shortcomings in the management of his complaint;
b) provide financial redress of £200 to take account of the time and trouble that Mr Y incurred in making his complaint;
c) respond to complaints raised in line with the Council's Complaints Procedure;
d) ensure that clear records are made about the nature of social services concerns in safeguarding matters in line with the All Wales Child Protection Procedures and its own case recording policies.

Quick fixes & Voluntary settlements

Neath Port Talbot County Borough Council – Other
Case reference 201300494 – March 2014
The complaint related to failings which had been identified during the stage two investigation into the standard of service received from its Social Services Department.

The Council agreed to pay a financial settlement to the complainant in recognition of the time and trouble in pursuing the complaint and the distress caused to his family. It also agreed to reimburse reasonable legal costs and to implement a stronger action plan which is to be shared with CSSIW.

Various Other

Quick fixes & Voluntary settlements

Cardiff and Vale University Health Board – Rudeness/inconsiderate behaviour/staff attitude
Case reference 201306235 – March 2014
The complainant, Mrs B, was unhappy with the treatment and care her late mother received whilst at Hospital during June 2013.

The investigation revealed that Mrs B had inadvertently forgotten to respond to a letter from the Health Board sent in December 2013 offering her a meeting with the Investigating Officer to discuss outstanding matters.

The Ombudsman contacted the Health Board who agreed to offer a further opportunity to meet and it was agreed that this should take place on 3 April 2014.

Pembrokeshire Housing Association Ltd – Other
Case reference 201305430 – February 2014
Mr X complained that Pembrokeshire Housing Association Ltd had failed to satisfactorily communicate with his daughter, Miss Y, regarding the complaints of damp and mould in her home.

The Ombudsman contacted Pembrokeshire Housing Association Ltd and as a consequence it has provided Miss Y with a B&Q Decorating voucher up to the value of £100 for the cost of paint for the entrance hall and inner hall. It has agreed to arrange for the leaking in the hallway to be repaired and replacement carpet in the hall, stairs and landing.

Ombudsman
PUBLIC SERVICES OMBUDSMAN FOR WALES

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We value any comments or feedback you may have regarding The Ombudsman's Casebook. We would also be happy to answer any queries you may have regarding its contents. Any such correspondence can be emailed to James.Merrifield@ombudsman-wales.org.uk or sent to the following address:

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