Our ref: PT/jm

Your ref:

Date: 9 July 2013

Ask for: James Merrifield

01656 644 200

James.Merrifield@ombudsman-wales.org.uk

Mr Paul Roberts
Chief Executive
Abertawe Bro Morgannwg University LHB
One Talbot Gateway
Baglan Energy Park
Baglan
Port Talbot
SA12 7BR

Dear Mr Paul

Annual Letter 2012-2013

Following the recent publication of my Annual Report, I am pleased to provide you with the Annual Letter (2012-2013) for Abertawe Bro Morgannwg University Health Board.

As outlined in my Annual Report, the number of new complaints to my office increased by 12% compared with 2011/12. Health complaints continue to be the most numerous type of complaint and now account for more than a third of all complaints received. Whilst some of the increase can be attributed to changes brought about under the Putting Things Right redress arrangements, the increase almost certainly reflects a greater dissatisfaction with the health service.

In reference to the overall performance of Health Boards in Wales, there has been a 35% increase in the number of investigation reports issued by my office during 2012/13 compared with 2011/12. I have also again had cause to issue a number of Public Interest Reports identifying serious concerns and failings, all of which have concerned health bodies. Whilst the average number of 'not upheld' reports issued against health bodies has remained the same as last year, I am disappointed to note such a large increase in the average number of 'upheld' reports from 11 to 21 reports.

It is worth noting a further year-on-year increase in the levels of 'Quick Fixes' and 'Voluntary Settlements' achieved by this office, from 13 to 16 cases. In order to maximise the opportunities to learn lessons from these types of cases, you can now

find the summaries of quick fixes and voluntary settlements included in my quarterly publication, The Ombudsman's Casebook.

However, I am disappointed to note that the amount of time taken by public bodies in Wales in responding to requests for information from my office has not improved. I am concerned that 45% of all responses took longer than five weeks, with 28% of responses taking in excess of 6 weeks. Whilst I appreciate that resources are stretched at this time, such delays obstruct me from providing complainants with the level of service which they should rightly expect to receive and I urge all Welsh public bodies to review their performance.

In reference to your Health Board, there has been a large increase in the number of complaints received by my office, compared with 2011/12. The largest number of complaints related to 'clinical treatment in hospital', which is noticeably above the average. It should also be noted that the number of complaints taken into investigation has almost doubled, compared to 2011/12. Whilst it is pleasing to note that there has been an increase in the number of quick fixes and voluntary settlements, there has also been a large increase in the number of 'upheld' reports issued by my office, which is now in excess of the average. It has also been necessary for my office to issue three Public Interest Reports. It is disappointing to note that half of responses to requests for information from my office were received more than five weeks after they were requested, and a third took more than six weeks.

As with previous exercises, I have copied this correspondence to the Chair of your Health Board with the intention that it be considered by the Board. I would also welcome the opportunity to meet and my office will be in contact shortly to make the necessary arrangements. Finally, a copy of this letter will be published on my website.

Yours sincerely

Peter Tyndall
Ombudsman

Copy: Chair, Abertawe Bro Morgannwg University Health Board

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received by my office in 2012-2013 with the average for health bodies (adjusted for population distribution[1]) during the same period.

Section B provides a breakdown of the number of complaints received by my office, broken down into subject categories.

Section C compares the number of complaints against the Health Board received by my office during 2012-2013, with the average for health bodies during this period. The figures are broken down into subject categories.

Section D provides the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013.

Section E compares the number of complaints against the Health Board which were taken into investigation by my office in 2012-2013, with the average for health bodies (adjusted for population distribution) during the same period.

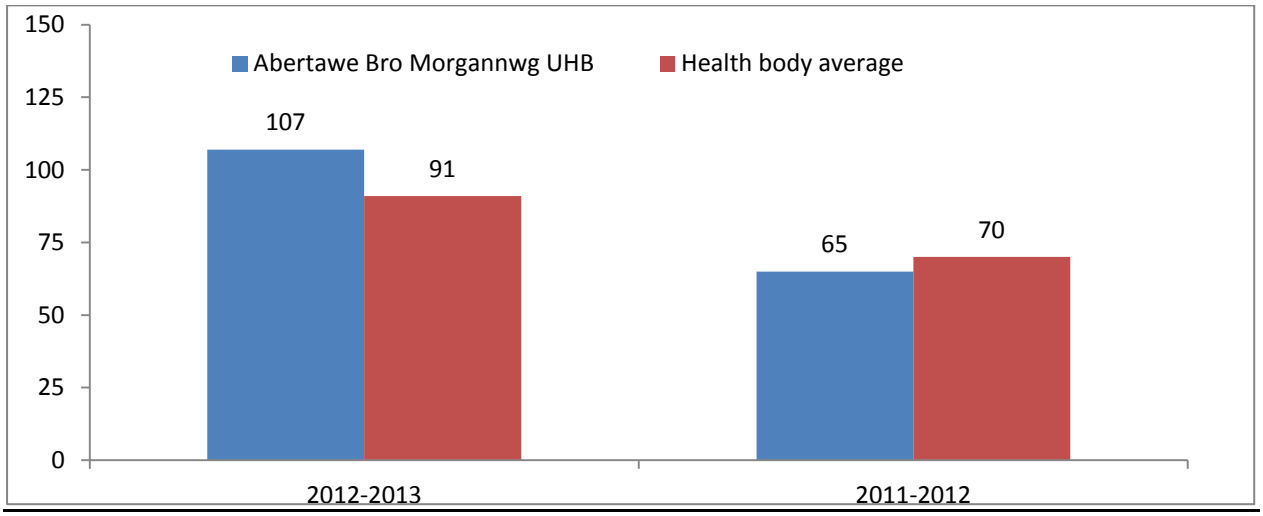
Section F compares the complaint outcomes for the Health Board during 2012-2013, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

Section G compares the Health Board's response times during 2012-2013, with the average response times for health bodies, and the average for all public bodies in Wales during the same period. This graph measures the time between the date my office issued an 'investigation commencement' letter, and the date my office receives a full response to that letter from the public body.

Finally, Section H contains the summaries of all reports issued in relation to the Health Board during 2012-2013.

[1] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262039

A: Comparison of complaints received by my office with average for health bodies

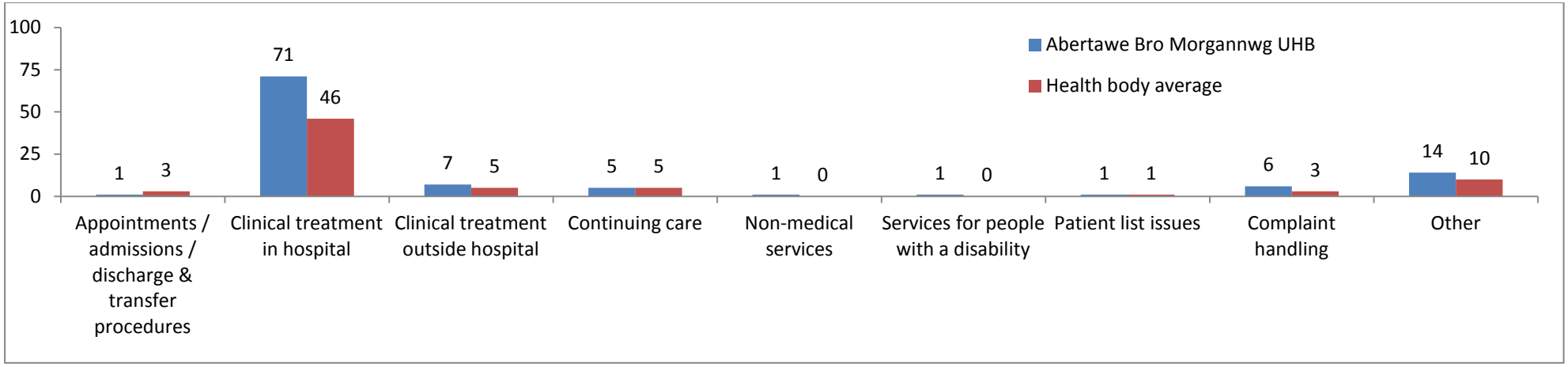


B: Complaints received by my office

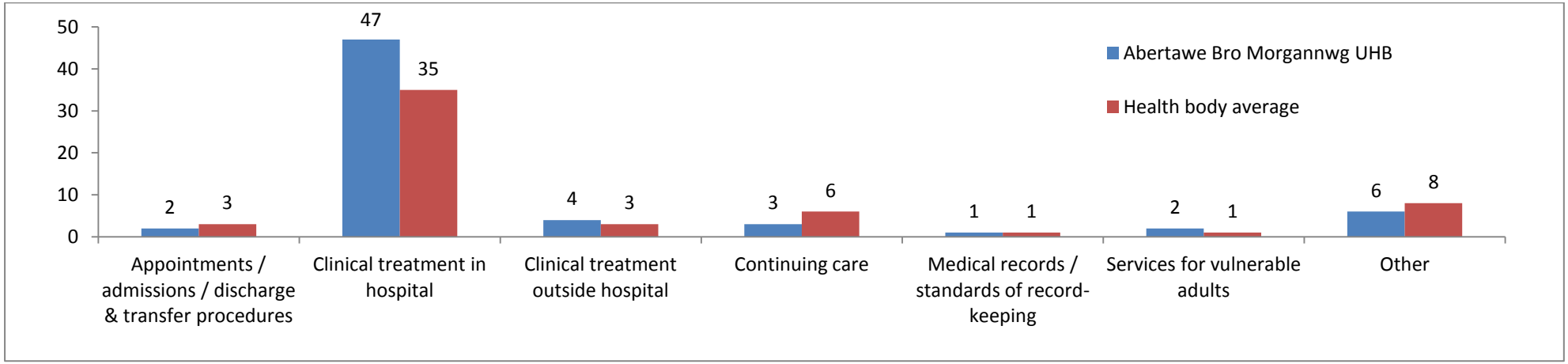
Subject	2012-2013	2011-2012
Appointments/ Admissions/ Discharge and transfer procedures	1	2
Clinical treatment in hospital	71	47
Clinical treatment outside hospital	7	4
Continuing care	5	3
Medical records/ Standards of record keeping	0	1
Non-medical services	1	0
Services for Vulnerable Adults	0	2
Services for people with a disability	1	0
Patient list issues	1	0
Complaint-handling	6	0
Other	14	6
TOTAL	**107**	**65**

C: Comparison of complaints by subject category with average for health bodies

2012-2013



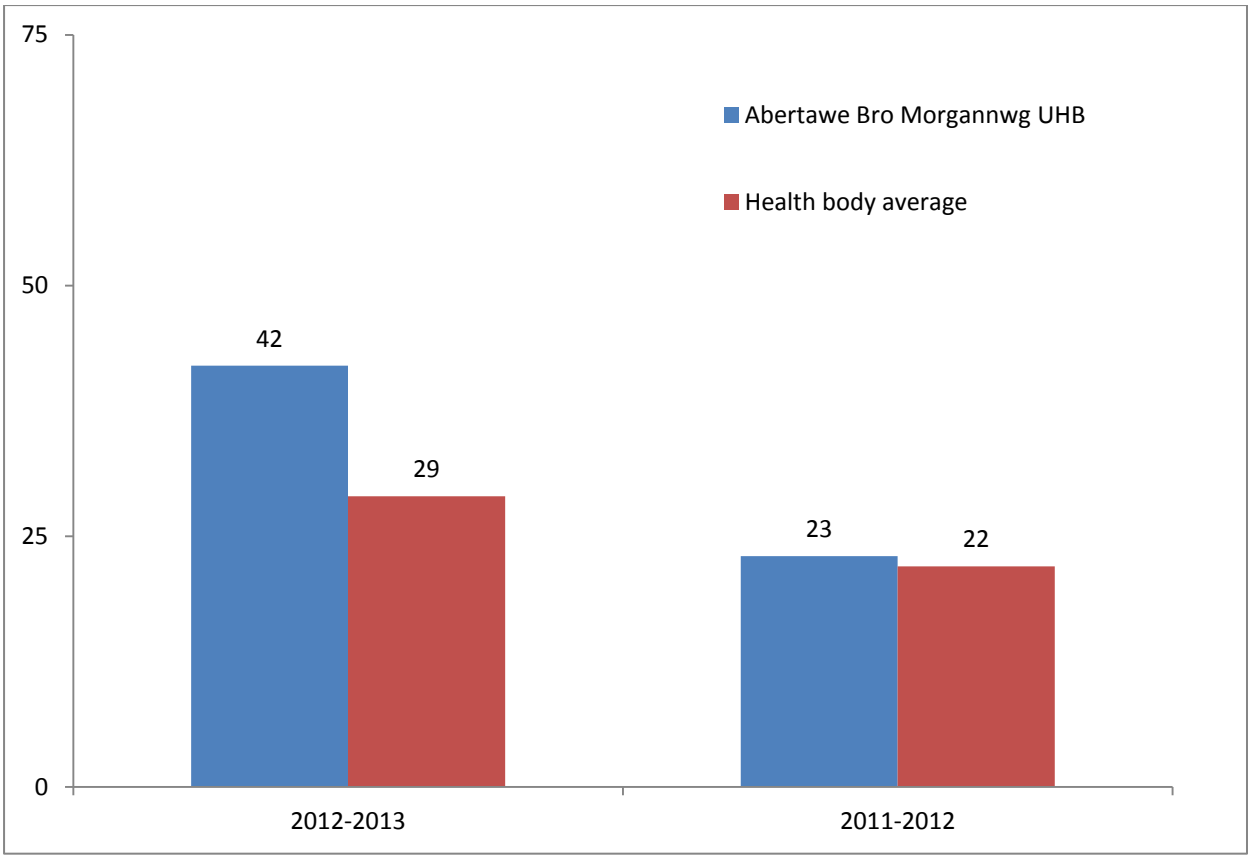
2011-2012



D: Complaints taken into investigation by my office

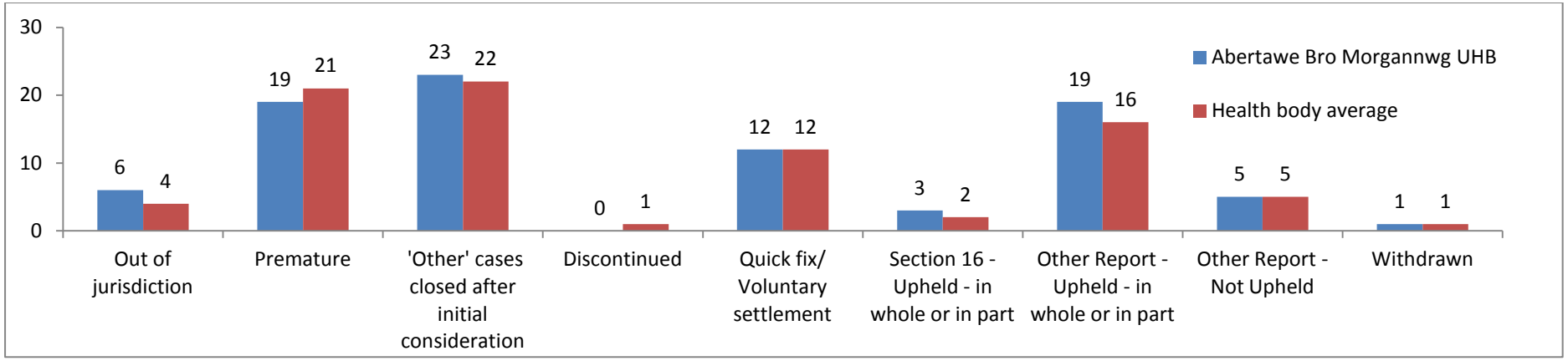
	2012-2013	2011-2012
Number of complaints taken into investigation	42	23

E: Comparison of complaints taken into investigation by my office with average for health bodies

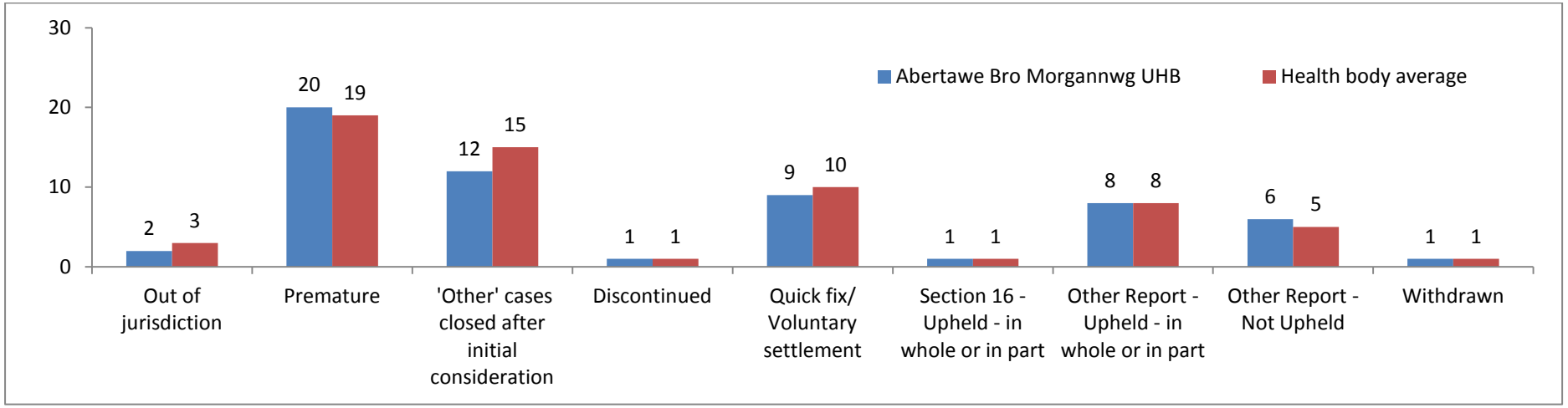


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

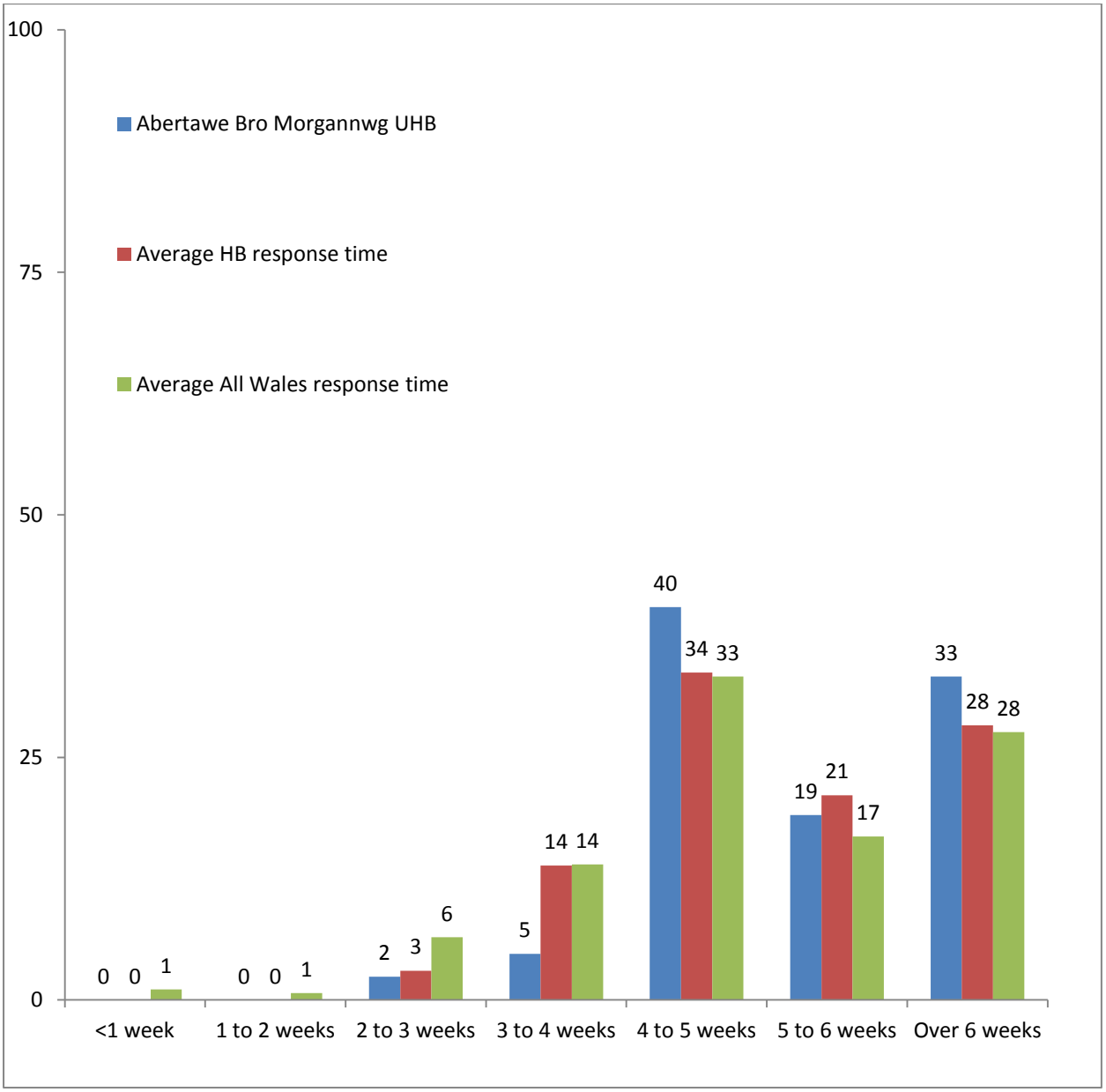
2012-2013



2011-2012



G: Comparison of Health Board times for responding to requests for information with average for health bodies and All Wales response times, 2012-2013 (%)



H: Report summaries

Health

Public Interest Reports

March 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mr B underwent complex bowel surgery in July 2011 with a view to managing unpleasant symptoms. He very sadly died six days later. The investigation considered the following complaints:

• the extent and risks of surgery were not fully explained to Mr B;
• there were insufficient investigations and bowel preparation prior to surgery, and the surgery itself was not appropriate; and
• Mr B's partner was not told of the outcome of surgery until he deteriorated.

The Health Board said that there had been a 'long and detailed consent process'. However, there was no evidence of this. The Ombudsman upheld the complaint and found that Mr B was only made fully aware of the extent of the surgery shortly before he was taken to theatre. The Ombudsman concluded that he was not made aware of all the potential risks involved, and that he went into major surgery, which ultimately led to his death, without having been fully informed or being in a position to give proper consent.

The investigation found a divergence of opinion about whether pre-surgery investigations were needed. None were undertaken. However, it was suggested that Mr B's case should have been discussed within a multi-disciplinary team forum prior to surgery, and the Ombudsman asked the Health Board to consider this.

Having carefully considered all the evidence, the Ombudsman concluded that the surgery was too risky for symptom control only, unless Mr B had wished to proceed on a fully informed basis. The Ombudsman found that the surgeon was acting at the limit of his skills in undertaking such complex surgery. The Ombudsman upheld this complaint. Finally, the Ombudsman found that it would have been good practice for Mr B's partner to have been told of his deterioration sooner than she was and the Ombudsman also upheld this complaint.

The Ombudsman made a number of recommendations to the Health Board which it agreed to implement. These included a payment of £5000 to Mr B's partner for the distress caused by the failings identified, and to acknowledge the uncertainty she lives with over whether Mr B might have lived.
Case reference 201201214

March 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mr O had a diagnosis of dementia. He was admitted to Cefn Coed hospital in 2009 and remained there until his death four months later. His daughter, Miss O, complained about aspects of his care towards the end of his life.

Mr O was assessed as 'at risk' of developing a pressure sore. Despite this, he was not re-assessed until after he developed significant pressure sore two months later. Had assessment and further preventive measures been taken, it is possible that the pressure sore might not have happened.

There was a lack of nutritional assessment, and Mr O was not referred to a dietician. Further, he should have been referred to a Speech & Language Therapist for a swallow assessment. Without regular nutritional assessments and without the input of a dietician and SALT, it is reasonable to conclude that the provision of food and fluid to Mr O was not as good as it could have been.

No end of life care pathway was in place at the time of Mr O's death, and his end of life care did not comply with the principles of palliative care. Nor was his pain management reasonable or consistent with guidelines. It therefore seemed likely that his pain management was insufficient on occasions.

The investigation investigation identified patterns of failures to assess (pressure care, nutrition), to refer (to SALT, to a dietician, to palliative care), and to plan (end of life care). This office has issued two other reports to the Health Board this year (201100120 & 201101689) both which concerned elderly patients and in which some similar failings were identified, albeit at a different hospital and where the events occurred in 2008 and 2011. For that reason, the Ombudsman has referred this report to Healthcare Inspectorate Wales for it to take into account in planning its future inspections.

The Ombudsman made a range of recommendations to the Health Board to prevent similar failings happening again. The Ombudsman also recommended that the Health Board apologise to Miss O and her family, and pay her £2000 for the distress exacerbated by failures in care during her father's last weeks of life. The Health Board agreed to implement all my recommendations.

Case reference 201200787

February 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mr A complained that there had been a delay in diagnosing and treating Mrs A's, aortic dissection, and that clinicians had failed to communicate with either of them. Mr A also complained about Abertawe Bro Morgannwg University Health Board's ("the UHB") response to his letter of complaint.

Having reviewed all of the information, the Ombudsman found that unreasonable delays had occurred. Despite being aware of Mrs A's medical history, and Mr A's concerns that she was having a heart attack, Mrs A waited at least 35 minutes before any initial tests were undertaken, including any heart monitoring. Following a further wait Mrs A was examined and referred to a Registrar, where she waited an hour to be seen.

The medical notes suggest that following an examination of Mrs A the clinicians suspected that she had an aortic dissection, although there is no evidence to suggest that this information had been shared with Mr or Mrs A. Due to the serious nature of this illness and the high mortality rate, clinicians would be expected to prioritise the tests to diagnose this condition. However in Mrs A's case the clinicians failed to do

this, instead tests were undertaken to “rule in” other more common disorders rather than “rule out” the aortic dissection. Sadly, Mrs A passed away shortly after being diagnosed.

Finally the Ombudsman found that the UHB had failed to respond to Mr A’s letter of complaint in accordance with its procedure. The Ombudsman also found that there was no evidence that lessons had been learned and that remedies had been put into place to prevent this occurrence again.

The Ombudsman upheld the complaint and recommended that the UHB should apologise and pay the sum of £5000 to Mr A, and Mrs A’s children. The Ombudsman also recommended that relevant staff be reminded of the importance of communication with patients and relatives, and that complaint handlers be reminded of the requirements set out in the UHB’s interim complaints policy and procedures. Finally, the Ombudsman recommended that the UHB implement a pathway for treating patients presenting to the SAU with suspected aortic dissection.

Case reference 201103324

Other reports - Upheld

March 2013 – Clinical treatment outside hospital – Abertawe Bro Morgannwg University Health Board & Hywel Dda Health Board
Mr K complained to the Ombudsman about delays following the referral of his late wife for diagnosis and treatment from the maxillofacial department of Withybush Hospital to Morriston Hospital. Following surgery for a tumour in her mouth, Mrs K remained under the care of Morriston hospital. However, sadly the cancer returned and Mr K complained about delays by the hospital in identifying the recurrence of the cancer. The Ombudsman's investigation found that there had been an unreasonable delay in the initial referral of Mrs K to Morriston Hospital and that there was a further delay at Morriston before surgery was performed to remove the tumour. The Ombudsman found however that whilst the delay would have been distressing for Mr and Mrs K, there was no evidence that the delay would have impacted on the success or otherwise of the surgery.

The Ombudsman was unable to conclude on the basis of the evidence available that the care provided at Morriston Hospital was unreasonable in terms of identifying the recurrence of Mrs K's cancer. Accordingly the Ombudsman upheld the first two aspects of Mr K's complaint but did not uphold the third. He recommended that the Health Boards apologise to Mr K and to implement changes to their procedures.
Case reference 201201080 & 201201082

March 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mrs Y complained about the treatment of her late mother at the Princess of Wales hospital following her mother's admission with a suspected Deep Vein Thrombosis (DVT). (Mrs Y's mother had a previous history of DVT.) She said that her mother's warfarin (medication to thin the blood) was stopped, without advising the family, and resulted in her mother's death from blood clots in both lungs. In responding to the complaint the Health Board said that an alternative medication had been given when the warfarin was stopped.

The Ombudsman found that Mrs Y's mother's initial treatment was reasonable. Appropriate investigations were carried out for leg and joint pain, including a scan to rule out a DVT. While the scan result was not completely conclusive, he took into account advice from his professional adviser that the care was reasonable because Mrs Y's mother was still on a therapeutic dose of warfarin at that time. He also found that the Health Board's decision to stop the warfarin was in line with national guidance and was not unreasonable, because tests showed that there was a high risk of bleeding.

However the Ombudsman upheld the complaint because there was no evidence that an alternative drug had been given, which was a serious omission. Mrs Y's mother was not therefore given the best possible chance to avoid a DVT. He also found that there were shortcomings in the way in which the Health Board dealt with Mrs Y's complaint because a thorough investigation, including a check of the medical records, had not been carried out. As a result the Health Board had wrongly advised Mrs Y that an alternative treatment to reduce the risk of DVT had been given. He required the Health Board to apologise and make payments of £750 and £500

respectively for the clinical failing and for misleading Mrs Y during the complaint handling.

Case reference 201200853

March 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mr E complained about the standard of care provided to his late wife, Mrs E, at Singleton Hospital. Mrs E had radiation enteritis which had affected her ability to tolerate food and compromised her nutritional intake. Her condition had been managed under the care of a consultant gastroenterologist for several years and, whilst her weight was low, it had remained stable. However, in January 2011, her nutritional intake deteriorated and she began to lose weight.

She was admitted to hospital on 18 January and discharged the same day. She was admitted again on 28 January, NG feeding was started followed by intravenous feeding on 11 February. However, she subsequently contracted an infection and sadly died in April. Mr E complained about several aspects of her care.

The Ombudsman found that there had been shortcomings in the care provided to Mrs E. She was not properly assessed on her initial admission on 18 January and her discharge was inappropriate. On her second admission, there was also criticism of the care of Mrs E's hickman line by nursing staff and the poor recording of this care. There was also no record or management plan of Mrs E's transfer from HDU back to the ward. However the Ombudsman made no criticism of her nutritional management or of the management of her infection.

The Ombudsman made the following recommendations:

- provide training/retraining nursing and healthcare staff in the care and management of central venous catheters (and the appropriate recording of that care);
- ensure that all patients discharged from ITU/HDU should have an appropriately detailed management/discharge plan and that details of these patients should be passed to the critical care outreach team;
- review its policies on catheter care, sepsis, critical care outreach/stepdown and discharge planning;
- ensure that appropriate investigations are arranged and a follow-up plan instigated before a patient is discharged; and,
- ensure regular auditing of its medical and nursing documentation.

The Ombudsman was also critical of the Health Board's response to Mr E's complaint as no written response to his complaint was ever given. The Ombudsman also recommended that the Health Board should review its complaint processes.

Case reference 201103838

February 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Ms J complained about the standard of care provided to her mother, Mrs L, at Singleton Hospital. Mrs L had advanced ovarian cancer. The main part of the cancerous tumour was removed surgically; the plan being to treat the remaining

tumour with chemotherapy. However, following surgery, Mrs L became unwell. She developed sepsis and sadly died several days later.

The Ombudsman found that, whilst the majority of care provided to Mrs L was reasonable, there were some shortcomings in her care. In particular, there was a lack of initial recognition of Mrs L's sepsis when there was sufficient information available (and in particular a white cell count of 3.7) to indicate this. There was no further investigation to identify the cause of the sepsis and no early involvement of the ITU/critical care team or consultant microbiologist. It was impossible to say if early recognition of Mrs L's sepsis would have led to a different immediate outcome, but there is a small chance that it may have.

The Ombudsman recommended that the Health Board apologise to Mrs L's family for the shortcomings. In addition, the Health Board agreed to the following recommendations:

- review its documentation and policies in relation to the early recognition of and care of patients with sepsis to ensure that they are in line with current best practice and fully support staff in ensuring the timely identification and treatment of sepsis;
- review the circumstances of this case to ensure that appropriate consultant and microbiology input are sought and are available at the earliest possible stages when sepsis is suspected and this information should be reflected in the Health Board's sepsis policies and pathways referred to above; and,
- ensure that all relevant staff have received appropriate and up-to-date training on recognising and dealing with sepsis, and the Health Board's policies and procedures on sepsis.

Case reference 201200485

February 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Ms C and Ms C complained about a number of issues concerning the care provided by the UHB to their late mother from July 2011 to her sad passing in August 2011. These included concerns about whether Mrs C's request for her personal care not to be provided by made carers were adhered to, the adequacy of her food and medication intake, concerns around a fall she sustained on 15 July and visiting times on the ward.

The Ombudsman found that Mrs C's wishes for her personal care not to be provided by male carers should have been documented in her care plan and medical records. Whilst the Ombudsman recognised that some non-intimate care could have been delivered by male carers, he was critical that Mrs C's wishes were not appropriately documented and upheld the complaint. With regard to Mrs C's nutrition and medication, the Ombudsman was satisfied that she received adequate nutrition and medication and did not uphold the complaint. With regard to Mrs C's fall, no falls risk assessment or care plan had been carried out by the UHB prior to the fall. Given that it was not possible to identify the measures put in place by the UHB to minimise Mrs C's risk of a fall, the Ombudsman upheld the complaint. The Ombudsman noted that visiting hours on the relevant ward had already been increased and whilst he upheld the complaint that the complainants were not permitted to stay overnight on two

occasions, he noted that the UHB had already apologised for its actions in that regard.

The Ombudsman did not uphold a number of complaints made regarding Mrs C's medical care. He did not find there was an unreasonable delay in the UHB carrying out a scan for Mrs C. Overall, the Ombudsman was satisfied that the treatment Mrs C received from the UHB was reasonable in the circumstances. He partially upheld the complaint to the extent outlined above.

Case reference 201201647

January 2013 – Patient list issues – Dentist in Abertawe Bro Morgannwg University Health Board area and Abertawe Bro Morgannwg University Health Board

Mr A was a long standing patient at the dental practice. However, following a difficult conversation with a member of practice staff, Mr A was informed when he next requested treatment that the practice would not treat him. Mr A subsequently complained to the Health Board about the manner in which the practice had handled the decision to remove him from the practice's list of patients. However, after nine months, Mr A still had not received any written response to his complaint and therefore complained to the Ombudsman.

The Ombudsman found that whilst the practice was entitled to remove Mr A from its practice list and refuse him treatment, it did not do so in a reasonable manner and in accordance with the relevant regulations. He also found that the Health Board had failed to respond to Mr A's complaint and had not dealt with his concerns in accordance with Welsh Assembly regulations. He upheld the complaint and recommended redress to Mr A of £50 from the practice and £150 from the Health Board, along with a number of procedural changes.

Case reference 201200980 & 201200982

January 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs P complained about aspects of the care and treatment of her late husband by Abertawe Bro Morgannwg University Health Board. He sadly died in April 2011 having been diagnosed with a pharyngeal pouch (a pouch which forms inside the throat). Mr P's clinical care was complex and he was seen by a number of different specialists, including a chest physician and ENT consultant. However, he died unable to eat and having lost a significant amount of weight.

The Ombudsman did not uphold Mrs P's complaints that there had been a delay in diagnosing the pharyngeal pouch, and about the treatment of it. However, the Ombudsman upheld her complaint that there had been a lack of action regarding Mr P's weight loss, in particular in the need to consider the possibility of tube feeding. Mr P's weight loss contributed to his increasing frailty and the increasing risks of surgery. The Ombudsman made the following recommendations, which the Health Board accepted:

- apologise to Mrs P;
- share the Ombudsman's report with the clinicians involved in Mr P's care; and

- discuss the report in appropriate consultants' forums and with the clinicians' appraisers to consider what lessons could be learned for their future practice.

Case reference 201201366

November 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs Y complained about her late husband's treatment at the Princess of Wales hospital shortly before his death. She said that there was delay in admitting him to hospital and in reaching an accurate diagnosis.

Mr Y had a history of heart attacks, there were clinical signs that his overall condition was poor, with a possible chest infection and he was complaining of stomach pain. The initial diagnosis was gallstone disease. The Ombudsman found it was completely inappropriate to discharge Mr Y on 13 January (his second attendance at 'A and E') in the early hours of the morning, whereas he should have been admitted and seen by a consultant physician later that morning. The Ombudsman upheld that part of Mrs Y's complaint and made a recommendation for the Health Board to review its general discharge arrangements. Although he could not say that the outcome would have been any different had this not happened

The Ombudsman found that overall Mr Y's care following admission to hospital the following day was reasonable and once the possibility of gallstone disease was excluded the appropriate referrals were made. But he suggested that Mr Y would have been better admitted under the physicians instead of as a surgical patient. He asked the Health Board to review the surgical team admission policy for patients with heart disease and to remind its surgery team members that there was a 'duty of care' to the whole patient not confined to any specific disease (gall stone disease in this case) being confirmed or excluded.

Case reference 201103067

November 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs E complained about the care and treatment that her late father, Mr H, received at Morriston and Singleton hospitals, which come under the Bro Morgannwg University Health Board. Mr H was admitted to Morriston Hospital on an emergency basis as he had pain in his side and back and became unable to stand unassisted. Mr H had a history of chronic pulmonary obstructive disease. Tests and scans were carried out and it was discovered that Mr H had advanced lung cancer which had already spread into his spine. As the cancer was too advanced for treatment Mr H was referred to Singleton Hospital for urgent radiotherapy and palliative care. It was initially believed that he could be transferred home, with appropriate support. Sadly, Mr H's condition deteriorated and he died in hospital.

The family complained that Mr H's dignity had not been preserved whilst in hospital and that his chronic constipation had not been attended to at either hospital. They said that the ambulance transfer had not been satisfactory and the transfer had taken place in the middle of the night. The family was concerned that the plan to transfer him home had not been put into effect quickly enough and said that he was in pain and discomfort in his final days.

The Ombudsman's clinical adviser in oncology said that the decision to refer Mr H for radiotherapy was appropriate and confirmed that surgical intervention would not have been appropriate in his case. There were however deficiencies in communication with the family and in the management of Mr H's constipation but none that were evident in relation to the management of his pain. The nursing adviser said there were communications failings and a lack of appropriate planning in relation to the intended discharge of Mr H and in relation to his bowel function. She was highly critical of the fact that the ambulance transfer had taken place in the middle of the night and that Mr H's dignity had not been preserved at all times. A number of recommendations were made for the training of staff in dealing with family members at the time of a person's demise, complex care planning and with regard to dignity of patients.

Case reference 201102926

November 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Ms A's complaint concerns the treatment she received during the birth of her baby in July 2011. She said that the midwives failed to provide her with the care she needed during her labour and also failed to provide her and her baby with postnatal care. Ms A said that the poor treatment she received was due to her ethnicity.

The Ombudsman's investigation concluded that the management of Ms A's labour was reasonable. Although he recognised that Ms A's poor experience had left her feeling that she was less favourably treated due to her ethnicity, the Ombudsman found no substantive evidence that this was the case. He noted that it was unfortunate that Ms A's details were not passed to the community midwifery team for follow up postnatal care. Whilst the Ombudsman accepted that this might have been due to a clerical error, he was critical that there was no evidence that this had been robustly investigated by the Health Board. The Ombudsman added that where, as in this instance, a pathway for labour is not followed the reasons should be documented and any variances in care set out. As well as being good practice it was appropriate within the context of the Health Board's equality duty. Ms A's complaint was therefore upheld to that limited extent.

The investigation also identified instances of record keeping not being as robust as it might have been and the Ombudsman emphasised that entries made by student midwives' should be countersigned by nursing staff.

Amongst the recommendations that the Ombudsman made were that the Health Board should apologise to Ms A for the failings identified during the investigation and should put in place measures to prevent a recurrence of the failings identified.

Case reference 201103492

November 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs D complained about the care and treatment provided to her elderly father, Mr A, who had dementia. In particular, she complained about the level of medication prescribed to Mr A which she said led to his being overly sedated. She felt that this contributed to the fact that he fell and broke his hip shortly after his admission. She queried the accounts given of his fall. Mr A sadly died several months later.

Having obtained clinical advice, the Ombudsman found that the level of medication prescribed to Mr A was in line with accepted clinical guidelines and Mr A's presenting condition. The complaint about the clinical care was not upheld. However, the adviser highlighted that the potential overuse of medication treatment in elderly agitated patients should be an area of concern for all those involved in elderly psychiatric care. The Ombudsman therefore suggested that it would be good practice to ask the Health Board's pharmacist to look at ways of reducing polypharmacy (the use of several different drugs and drug types at the same time) for elderly agitated patients.

The Ombudsman partly upheld the complaint about the reporting of Mr A's fall. The incident report form detailing Mr A's fall was inaccurate and incomplete. During the course of the investigation, it transpired that the Health Board was unable to locate Mr A's original medical notes for over seven months until after a draft of this report was issued. This was unacceptable and called into question the robustness of the Health Board's procedures for tracking and filing its records.

The Ombudsman made several recommendations, including that the Health Board should:

- Apologise to Mrs D,
- Review its arrangements both for reporting and investigating incidents,
- Review its procedures for tracking and filing its clinical records to ensure that its system was robust. This was particularly in respect of mental health records.

Case reference 201102272

October 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mr A complained about the delay in transferring his father to Morriston Hospital ("the Hospital"). Mr A raised a number of queries. These included whether the delay had worsened his father's prognosis and whether his father's discharge was appropriate six days after surgery, given his complicated clinical condition. Finally, he complained that the Health Board had failed to provide advice for the medication prescribed to his father on his discharge.

The Ombudsman's investigation concluded that although Mr A's father had a number of risk factors the surgery itself and his initial post operative recovery were uncomplicated. In view of this the timing of Mr A's father's discharge was appropriate and in keeping with best practice. Mr A's father's clinical management was also considered reasonable. Therefore, these aspects of Mr A's complaint were not upheld.

The Ombudsman concluded that failure to provide medication advice to Mr A's father on discharge was poor practice. Administratively, shortcomings in clinical recordkeeping were identified that were not in keeping with the GMC's guidance. These service failings led to Mr A's complaint being upheld.

The Ombudsman recommended that the Health Board should apologise to Mr A through its Chief Executive for failings identified by the course of the investigation. The Health Board was asked to draw up a policy for the management of patients following coronary surgery; to remind the clinicians of the importance of recording clinical discussions on patients' medical records and to remind its staff about the importance of ensuring that patients are provided with appropriate advice about any medication prior to discharge.

Case reference 201102962

October 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs T had a number of concerns about the treatment her late father ("Mr B") received at two hospitals under the governance of the UHB over a number of months (admissions/discharges March – July 2008). Mr B, sadly, died at home on 30 July 2008. Mr B, who had a number of health complaints including cardio vascular disease, was initially admitted with a painful ischaemic foot (tissue damage owing to lack of circulation which can result in ulcers and wounds to the leg that are difficult to heal). Despite surgery to remove a clot, a wound to his leg did not improve. Mrs T's complained about the following matters relating to her father's care: nutrition / hydration issues; pain relief; treatment of her father's leg / Urine Tract Infection (UTI) and wound management; and his discharges from hospital/ failure to diagnose a pneumothorax (a collapsed lung, which can occur either after a trauma to the chest or, in some patients, spontaneously). She also complained about the time and quality of the UHB's investigation into her complaints.

The investigation found a number of failures in relation to Mr B's admissions: no nutrition assessments /care plans completed, no food/fluid charts and no timely referral to a dietician; some periods of inadequate wound management; and inconsistency in medication charts, so that it was possible Mr B did not receive adequate pain relief. It was also evident that he was considered to be at the end of his life but no end of life pathway documentation was completed and no evidence that appropriate end of life care was delivered. These elements of Mrs T's complaints were upheld. However, the Ombudsman's clinical advisers were satisfied that no further action was possible regarding Mr B's leg; amputation was discussed but Mr B was too unwell to undergo such an operation. He was appropriately treated with antibiotics for the UTI and there was no way of knowing when or how the pneumothorax occurred. His discharges were considered appropriate overall. After Mrs T first complained about her father's care, the UHB made a POVA referral, and an investigation was undertaken, which itself was delayed. Thereafter, delays occurred with the UHB's own investigation, which the Ombudsman found to be "unacceptable", so this concern was upheld.

The Ombudsman made the following recommendations to which the UHB agreed: that it apologised to Mrs T for the failings identified and pay her £400 for the time and trouble she had gone to in pursuing the issues for an unacceptably long period of time. In view of the passage of time (events of 2008), evidence provided by the UHB, and other recommendations made by the Ombudsman in his earlier investigations (on events later in time), further recommendations were not considered necessary in the circumstances.

Case reference 201101689

October 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mr and Mrs A complained about the management of their son, child A's care, when he contracted PVL positive MRSA ("PVL MRSA") a virulent form of MRSA. Amongst the concerns that they raised was that the Princess of Wales Hospital's dermatology clinic had failed to advise them of child A's PVL MRSA diagnosis in August 2009 when they attended an outpatient clinic review that they requested. Mr and Mrs A also highlighted the impact of the failings on the family. This included their other son, child B, contracting PVL MRSA and both children having to undergo surgery. Child A had been left with extensive scarring on his leg as a result of the infection. Finally, they expressed dissatisfaction with the Health Board's handling of their complaint.

The Ombudsman obtained clinical advice from his Professional Advisers which he considered in reaching his conclusions. The Ombudsman's investigation concluded that had Mr and Mrs A been informed of the PVL MRSA diagnosis that when child A presented at the Emergency Department (on 7 October 2009) with a skin infection, information about the PVL MRSA may have led to different treatment and therefore a reduced hospital stay and a better outcome. In addition, one of the Ombudsman's Professional Advisers (an Infection Prevention and Control Nurse) also identified inadequacies in the treatment, screening and decolonisation regime applied at the dermatology clinic aimed at eradicating the PVL MRSA and preventing its spread. This led the Ombudsman to conclude that he could not rule out the possibility of there being a causal link between the failings identified and child B acquiring the infection. Finally, noting the Health Board's acceptance in this case that their complaints handling had been "unacceptable" the Ombudsman commented on the fact that the Health Board's investigation into Mr and Mrs A's complaint had not been sufficiently robust.

The Ombudsman's recommendations included the following:

- that the Health Board's Chief Executive should apologise for the failings identified. In addition, in recognition of the distress and inconvenience caused to Mr and Mrs A, which extended to how the Health Board dealt with their complaint, the Health Board should make a payment of £1,000.
- that given the impact of the Health Board's failings on the children, the Health Board should make a payment of £1,000 to child A and a payment of £500 to child B.

Case reference 201101775

October 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs M complained about the standard of care her husband received in hospital. Her complaints included a lack of professional collaboration; poor communication; poor discharge planning; and a lack of continence rehabilitation. Mrs M said that, as a result of this, her husband's dementia, mobility and general health deteriorated during the course of his admission.

The Ombudsman found that the overall standard of care was good and that there was no evidence to suggest that any deterioration in his condition could be attributed to the standard of care he received. However, the Ombudsman did find that there

were some failings in respect of Mr M's discharge planning, albeit that most of these failings were due to circumstances outside of the Health Board's control, relating as they did to delays in the provision of social services by the local authority. The Ombudsman also found there to have been some failings in respect of incontinence management and rehabilitation.

The Ombudsman recommended that the Health Board should apologise for the failings identified, should take practical action to improve its co-ordination with other agencies in respect of discharging patients and should remind relevant staff of the importance of employing continence promotion strategies.

Case reference 201101859

September 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Ms A's complaint concerned the lack of midwives on the ward at a hospital ("the Hospital") during her inpatient stay in October 2011. Ms A also said that there was an overall delay in her labour being induced and that she had not been given one to one midwifery care as set out the National Institute for Health and Clinical Excellence guidance ("NICE guidance"). Ms A also complained that insufficient midwifery cover led to her not receiving adequate pain relief.

The Ombudsman's investigation concluded that once Ms A was in established labour she had received one to one care and this was in keeping with NICE guidance. Therefore this aspect of Ms A's complaint was not upheld.

However the Ombudsman's investigation highlighted that the Health Board had missed an opportunity to address Ms A's concerns when she initially raised them with the community midwife. There was also some delay in responding to Ms A's subsequent formal complaint. The Ombudsman concluded that had the Health Board acted more promptly and responded more adequately than it did this might have prevented Ms A making a complaint to this office. This aspect of Ms A's complaint was upheld. Amongst the recommendations the Ombudsman made were that the Health Board should apologise to Ms A for its failure to address her complaint in a timely manner. It should provide an action plan setting out how it intended to deal with those shortcomings that it had not previously addressed. Finally, it should take steps to ensure that its complaints procedure was compatible with the aims and objectives of the Welsh Government's Model Concerns and Complaints Policy and Guidance.

Case reference 201102836

August 2012 – Other – Abertawe Bro Morgannwg University Health Board & GP practice in Abertawe Bro Morgannwg University Health Board area

Mrs L complained about the manner in which the GP Practice cancelled an appointment she made as a visiting patient following a difficult conversation with a member of the Practice's staff. She considered that the Practice took the decision to refuse her the appointment without investigating or considering her account of what was said. She was also dissatisfied with the Practice's response to her subsequent complaint and with the Health Board's decision to refer the complaint made to it about the Practice back to the Practice for them to investigate.

The investigation found that the Practice failed to investigate and consider Mrs L's concerns appropriately before deciding to refuse her treatment. It also found that the Practice and the Health Board's actions were not in keeping with the Welsh Government Guidance – "Putting Things Right". Recommendations were made that staff be reminded of the expectations of the guidance with appropriate training being provided. Policy changes were also recommended, as well as redress of £100 each by the Health Board and the Practice together with appropriate apologies.
Case reference 201102834 & 201102835

August 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Ms X complained about the care and treatment provided to the late Mr Y at Morriston and Gorseinon Hospitals (from April - August 2010).

Ms X raised concerns about the various diagnoses made, investigations carried out and treatment plans put in place for Mr Y. It was clear that Mr Y had a number of health concerns during his admission. However taking account of clinical advice, the Ombudsman found that Mr Y did receive proper assessment of his various clinical conditions and did receive appropriate treatment. There was nothing to suggest that Mr Y's overall clinical care during this period was unreasonable. As a consequence, the Ombudsman did not uphold this element of the complaint. The Health Board was however invited to review the availability and responsiveness of its dermatology service.

Ms X also expressed concern about the procedures in place for the management of MRSA infection and the way in which families are informed once a diagnosis is available. The Ombudsman, taking account of clinical advice, was of the view that appropriate clinical procedures in line with the policy of the Health Board were followed in relation to MRSA infection. However to the extent that it was not clear from the records whether the family were appropriately advised at the outset and in light of the Health Board's own acceptance of shortcomings in communication, the Ombudsman partially upheld the complaint in relation to family communication.

Ms X also raised concern about the management of Mr Y's confused state including an occasion when he left the ward unaccompanied and the shortcomings in communication with his family. Overall, the Ombudsman was of the view that appropriate clinical assessment and treatment was provided at the time. However he found that the absence of a formal risk assessment was a shortcoming. He was also concerned that there was no evidence that the family had been immediately advised of a significant incident. As a result of these two omissions he partially upheld this element of the complaint.

Finally, Ms X complained about two investigations carried out by the Health Board. The first related to shortcomings in communication when Mr Y was transferred to A&E and the second to verbal comments made which did not respect Mr Y's dignity.

It was clear that an error had occurred and incorrect information about Mr Y's transfer details was given to the family. The Ombudsman said that this was unacceptable and had caused unnecessary distress to the family. However, the Ombudsman did

not uphold the complaint that the Health Board had failed to treat this with sufficient seriousness.

In relation to the matter relating to Mr Y's dignity, the Ombudsman found that there was nothing in the records which related specifically to this and unfortunately he could not make a judgement on what had occurred. He did however invite the Health Board to review its processes for undertaking and recording complaint investigations.

The Ombudsman recommended that an apology be provided to Ms X for the absence of a risk assessment and the failure in communication with the family during Mr Y's confused episode. He also recommended that the Health Board ensured that risk assessments were carried out where there was evidence of challenging behaviour by patients and that nursing staff received violence and aggression training. He also recommended a review of the Health Board's practice for informing families where there had been a significant incident. He finally recommended that the Health Board ensured that it communicated with families appropriately where a patient had been found to have MRSA infection.

Case reference 201101421

June 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board area

Mrs G complained about how her husband, Mr G, was treated at one of the UHB's hospitals, where he sadly died, and its failure to reach a diagnosis of cardiogenic shock sooner, and so treat him. Sadly, Mrs G herself passed away before the investigation's conclusion.

The investigation found failings in Mr G's care, falling below what was a reasonable standard, including a lack of urgency in dealing with him and a failure to manage and transfer him sooner to a high dependency environment when all the clinical pointers (including his Modified Early Warning System score) warranted this. He was not moved from the Clinical Decisions Unit (CDU) for a number of hours. Subsequently, there were delays in his actual move even after the decision to transfer him had been taken. The Ombudsman's clinical adviser was also critical of a lack of consultant review, and an inadequate post-take ward round, resulting in no definitive plan for Mr G. Albeit the initial working diagnosis of sepsis, on Mr G's presenting symptoms on admission, and frontline treatment for that, was not unreasonable, no consideration was given as to whether there was another reason for his clinical condition when he was deteriorating. However, a post mortem was inconclusive as to whether Mr G's death resulted from cardiogenic shock. So it was not known whether he would have survived, if treated as he should have been and for cardiogenic shock, given his poor clinical condition on admission.

The UHB agreed to all the Ombudsman's recommendations, including:

• an apology to the family for the failures identified;
• £400 for the time and trouble in pursuing the complaint;
• that a senior clinician should audit a sample of post take ward rounds at the CDU to review patient planning; and that
• CDU clinicians should reflect on a report issued by the physicians' governing body regarding the management of acutely ill patients. **Case reference 201101176**

Other reports – Not Upheld

March 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mr W complained that he had vomited and aspirated shortly after being administered a general anaesthetic in preparation for planned surgery at Singleton Hospital, Swansea. Mr W was concerned that the pre-admission advice provided by the Health Board had been confusing, and he believed that his operation should not have been brought forward given that staff had been made aware of his dietary intake.

The Ombudsman found that the Health Board had complied with standard pre-operative fasting practice, and he therefore did not uphold the complaint. He did, however, share Mr W's concerns that the instructions about fasting in the pre-operative information sent to Mr W were inconsistent. The Health Board has since revised its pre-admission patient information on fasting to minimise the risk of confusion.
Case reference 201201209

March 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Miss G complained about the care she received from her midwife. She complained that the midwife had failed to properly check that the placenta had been delivered complete and that, due to some of the placenta being left inside her, she was subsequently admitted to hospital as an emergency due to a vaginal haemorrhage. Miss G complained that the standard of record-keeping by the midwife was poor, that a scan or test should have been carried out to check that no placental tissue had been retained and that the midwife should not have been working unsupervised.

The Ombudsman found that the midwife was entitled to work unsupervised and that her record-keeping was in accordance with national standards. The Ombudsman found that the records showed that the midwife had appropriately checked the placenta and that there was no routine test or scan to provide further confirmation. Overall, the Ombudsman found there was no evidence of any deficiency in the midwife's care and that she had performed her duties properly.
Case reference 201203094

January 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mr C complained about the standard of care and treatment provided to him by staff at the Princess of Wales Hospital. He had undergone surgery to his nasal septum (the vertical plane of tissue that separates the nostrils) on 10 December 2010. After the operation he felt unwell and had a foul smell in his nose, which led to him visiting the Emergency Department on 26 December. Mr C had suffered a perforated septum. The main complaint was about the care provided by the A&E Doctor who saw Mr C during that visit. Mr C also had a wider concern about the care provided to him by the ENT team.

The investigation found that the care and treatment provided to Mr C had been of a reasonable standard apart from during his visit to the hospital on 26 December. The

A&E doctor had failed to take advice from an ENT specialist about Mr C's condition, failed to document details of symptoms or findings relating to Mr C's nose, or to record a diagnosis. The A&E doctor had also failed to document the results of tests performed on that day, or to keep Mr C in the Emergency Department until the results were available, or to follow them up. However, despite those failings it is unlikely that Mr C was caused a significant hardship given that whatever the A&E doctor had decided to do, it would not have affected the long term outcome for Mr C. The A&E doctor could not reasonably have been expected to assess what was a complex surgical picture and it would not have been appropriate or reasonable for him to debride Mr C's nasal wound. The complaint about the care provided on 26 December was therefore partly upheld while the complaint about the care provided by the ENT team was not upheld.

Case reference 201200487

August 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mrs H complained that, following an accident, the Health Board failed to check for a rupture of her bicep at a sufficiently early stage. Mrs H said that she was still suffering from a significantly reduced range of movement. Mrs H also complained that the period of time she waited for the ultrasound scan to be carried out was excessive.

The Ombudsman found that the Health Board had provided appropriate and timely treatment following Mrs H's accident. The Ombudsman noted his adviser's comments that it would have been impossible to have diagnosed Mrs H's rotator cuff tear immediately following her accident. Whilst the Ombudsman found that Mrs H waited 8 weeks for the ultrasound scan, the time period was within that permitted by the NHS in Wales for a diagnostic procedure and the Health Board had offered its apologies in this regard.

The Ombudsman did not uphold the complaint.

Case reference 201104021

July 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mr B complained about the podiatry treatment provided for him by Abertawe Bro Morgannwg University Health Board ('the Health Board'). He suggested that the Health Board cut his foot because its clinical practice was poor. He said that it did not tell him about this injury or advise him to see his doctor for antibiotics. He implied that this injury became infected as a result. He noted that he developed a foot ulcer. He said that his foot-related difficulties "ruined" his holiday, led to the postponement of his hip replacement operation and caused him and his wife inconvenience. He was dissatisfied with the Health Board's response to his complaint and requested an independent review. The Clinical Adviser, appointed by the Independent Complaints Secretariat ('the ICS Adviser'), expressed concern about some aspects of Mr B's podiatry care. The Lay Reviewer referred Mr B's complaint back to the Health Board for further local resolution. The Health Board responded to this referral. However, Mr B indicated that he remained dissatisfied because neither the Health Board nor the independent review had explained why the Health Board had compromised his treatment.

The Ombudsman did not uphold Mr B's complaint because the Health Board had apologised for the treatment failings identified by the ICS Adviser and taken sufficient action to address them.

Case reference 201100814

Quick fixes & Voluntary settlements

January 2013 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board

Mr O complained about the treatment that his late brother Mr O received whilst he was a patient on Ward 6 in Singleton Hospital. Mr O complained that his brother was taken off an intravenous fluid drip, he became dehydrated and his condition deteriorated. Mr O said that his brother was transferred to the High Dependency Unit (HDU) where he was sedated and put on a ventilator. However, Mr O was concerned that his brother remained sedated and believed that, if the care on Ward 6 was appropriate, this may have eliminated the need for his brother to be transferred to HDU.

Following consideration of the complaint, it was noted that Mr O had recently submitted additional concerns about aspects of his brother's care in HDU. Consequently, it did not appear that the Health Board had the opportunity to fully respond o the complaint, before Mr O made his complaint to the Ombudsman. The Health Board agreed to provide Mr O with a written response within a specified period of time.

Case reference 201203799

October 2012 – Complaint-handling – Abertawe Bro Morgannwg University Health Board

Mrs M's son was diagnosed with Aspergers Syndrome, Schizophrenia and Bipolar Disorder. Mrs M was concerned that her son's condition had been incorrectly diagnosed, and therefore requested a second opinion from a specialist. The Health Board agreed that a new specialist would carry out a further assessment. Mrs M was concerned that the new specialist was not a specialist in autism and therefore requested a further referral to an experienced Autism Spectrum Disorder specialist in England for diagnosis. The Health Board disagreed. Mrs M complained that the Health Board failed to respond to her correspondence, and raised concern about misleading and untrue correspondence.

Following contact by the Ombudsman's office, the Health Board admitted that it had failed to respond to Mrs M's letter, and agreed it would send its response and apologise to Mrs M for the delay it had caused. With regards to the information provided by the Health Board, it was apparent that there was some contradiction between the Chief Executive's earlier letter to Mrs M, and the action actually taken by the Health Board to transfer her son's care to a specialist. However, given that the Health Board explained in a later letter the reasons why the arrangements had not been made, and it apologised for the breakdown in communication and the distress caused to Mrs M, this was considered to be reasonable action on the part of the Health Board.

Furthermore, whilst the Health Board refused to fund an external referral to a specialist in England Mrs M had not requested a formal 'Individual Patient Funding Request', or identified any administrative and/or procedural shortcomings in the way that the Health Board reached its decision not to fund the referral.

Case reference 201202340

October 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
The complainant attended for an operation to remove some veins. Although the veins for removal were marked, one was not removed. The complainant also had an infection at the site of incision several months after the operation. The management in this case was found to be reasonable. However, it was felt that the reason why the vein was not removed had not been adequately explained to the complainant. The LHB agreed to write to him to explain further.
Case reference 201202442

August 2012 – Complaint-handling – Abertawe Bro Morgannwg University Health Board
Mr N complained that, after the Ombudsman referred his original complaint to the Health Board, he had not received a response in accordance with the timescale set out in the Health Board's complaints procedure. On receiving Mr N's complaint, my office contacted the Health Board, which agreed to send its final response to Mr N within two weeks.
Case reference 201201521

August 2012 – Continuing care – Abertawe Bro Morgannwg University Health Board
Mr B complained to the Ombudsman about the manner in which the Health Board had considered his mother's eligibility for continuing healthcare. It became apparent that the Health Board had not considered his mother's eligibility in accordance with the framework issued by the Welsh Government (the framework). It also appeared that the Health Board had not dealt with the concerns Mr B raised about his mother's assessment in accordance with the framework, choosing to refer the matter to the Health Board's complaints procedure.

Upon being contacted, the Health Board agreed to undertake a full assessment of his mother's eligibility for continuing healthcare funding in accordance with the framework and, if Mr B remained dissatisfied, provide him with the opportunity to pursue his concerns in accordance with framework.
Case reference 201201546

April 2012 – Continuing care – Powys Teaching Health Board & Abertawe Bro Morgannwg University Health Board
A complaint was made by Mrs X via her Solicitor about the application of NHS Continuing Health Care Eligibility Criteria (retrospective review) in her mother Mrs Y's case. The complaint concerned both Abertawe Bro Morgannwg University Health Board (ABMUHB) and Powys Teaching LHB which at the time operated an Independent Review Panel (IRP) on behalf of ABMUHB. ABMUHB made a recommendation to Powys Teaching LHB about the period of time which Mrs Y should be eligible for care and Powys Teaching LHB subsequently made a different recommendation which reduced the period of eligibility for Mrs Y.

In investigating the complaint the Ombudsman found that the process followed by ABMUHB was not in accordance with the relevant Welsh Government guidance on NHS Continuing Health Care. ABMUHB had failed to inform the family of its decision at the time prior to referral to Powys Teaching LHB. The family was not therefore

given the opportunity of accepting reimbursement for the partial period identified by ABMUHB.

Following the Ombudsman's involvement ABMUHB reviewed its actions and agreed that it had acted outside of the relevant guidance and accepted that Mrs X should have been consulted over the initial recommendation for partial reimbursement. This Health Board put its original decision to Mrs X and the family were satisfied with its judgement and suggested level of reimbursement.

The Ombudsman therefore considered it appropriate to discontinue his investigation as there was a satisfactory voluntary settlement.
Case reference 201101475 & 201101971

April 2012 – Clinical treatment in hospital – Abertawe Bro Morgannwg University Health Board
Mrs P complained that the Princess of Wales Hospital had been negligent in her son's care. She was also unhappy that her son was discharged before any results came through. Mrs P was worried as her son had not received any follow up care after his suspected stroke and felt this was unacceptable in any circumstances.

On receiving Mrs P's complaint, the Ombudsman contacted Abertawe Bro Morgannwg University Health Board to clarify whether it was acting upon Mrs P's complaint and the points she had raised. The Ombudsman was informed that the Health Board had received Mrs P's complaint relating to her son's care and a response had been given to the locality manager for final approval and signing. Unfortunately, the Ombudsman was not able to secure a date when Mrs P would receive this response but explained that she was free to contact the office again if she did not receive her response from the Health Board within the next three weeks.
Case reference 201200363