Our ref: PT/jm
Ask for: James Merrifield
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Date: 9 July 2013
James.Merrifield@ombudsman-wales.org.uk

Mr Geoff Lang
Acting Chief Executive
Betsi Cadwaladr University LHB
Ysbyty Gwynedd
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Dear Mr Lang

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 Betsi Cadwaladr 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, I note that both the complaints received and investigated by my office are lower than the health body average, and the majority of complaints received related to clinical treatment in hospital. I am pleased that the number of quick fixes and voluntary settlements remain above the health body average, whilst the number of upheld reports is below the average. However, it has been necessary for my office to issue one Public Interest Report in relation to your Health Board. The response times for your health board indicate that the majority of responses took more than 5 weeks, and over a quarter of responses took in excess of six weeks.

I would 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

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.

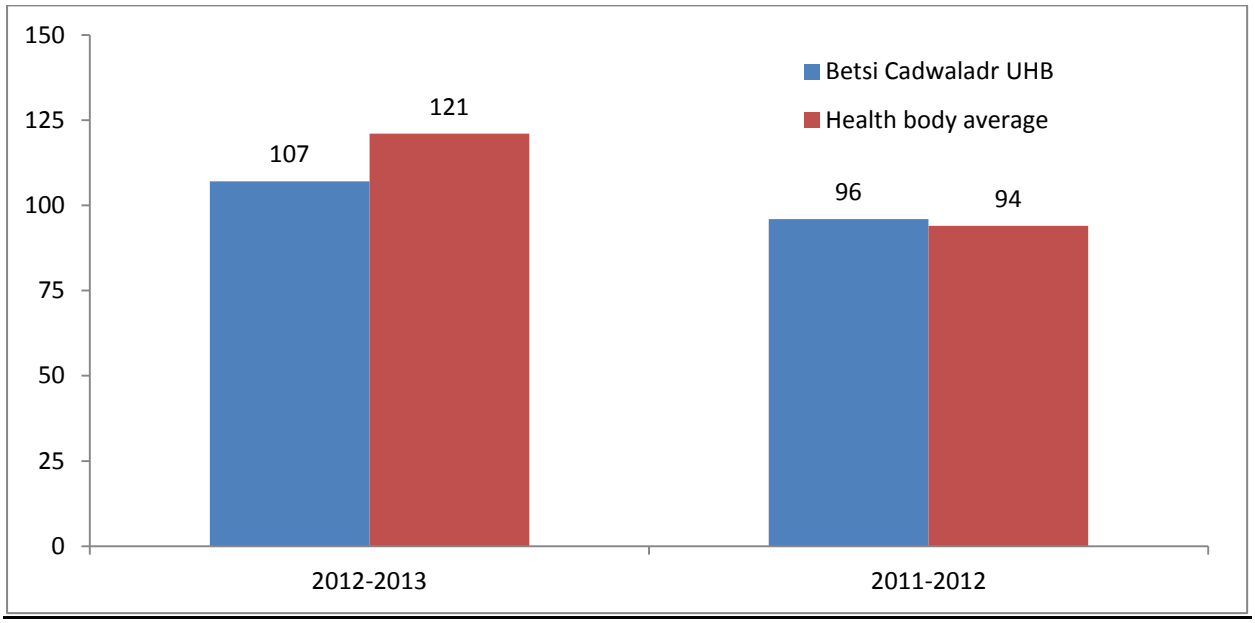
Section F compares the complaint outcomes for the Health Board during 2012-2013, with the average outcome for health bodies during the same period. Public Interest reports issued under section 16 of the Public Services Ombudsman (Wales) Act 2005 are recorded as 'Section 16'.

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

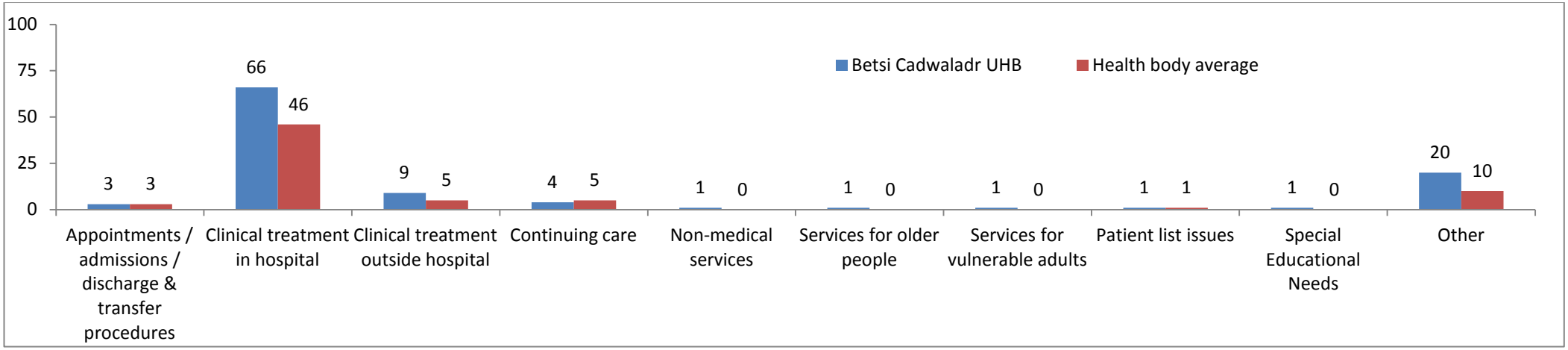


B: Complaints received by my office

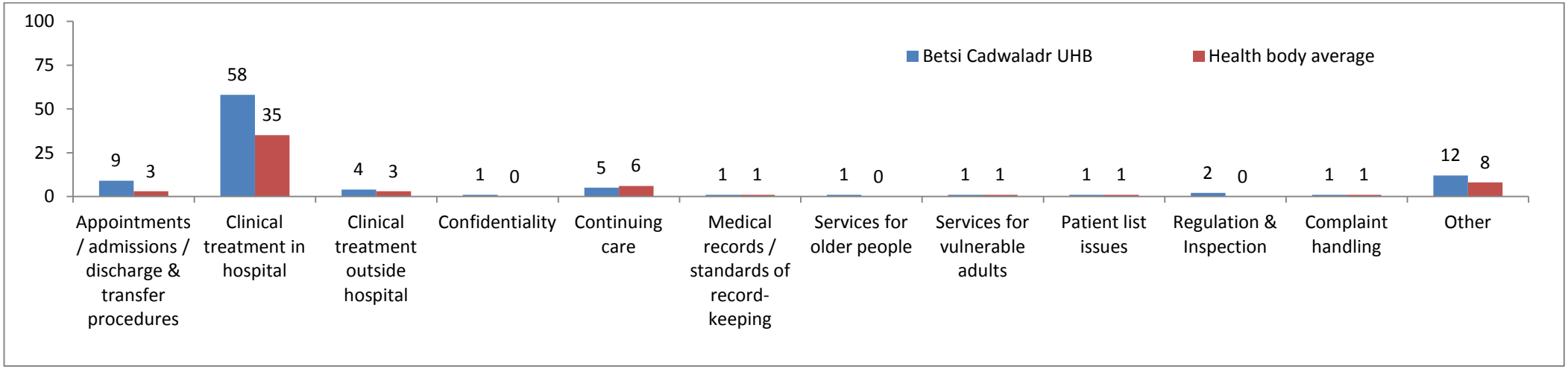
Subject	2012-2013	2011-2012
Appointments/ Admissions/ Discharge and transfer procedures	3	9
Clinical treatment in hospital	66	58
Clinical treatment outside hospital	9	4
Confidentiality	0	1
Continuing care	4	5
Medical records/ standards of record-keeping	0	1
Non-medical services	1	0
Services for older people	1	1
Services for vulnerable adults	1	1
Patient list issues	1	1
Regulation and inspection	0	2
Complaint-handling	0	1
Special Educational Needs	1	0
Other	20	12
TOTAL	**107**	**96**

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

2012-2013



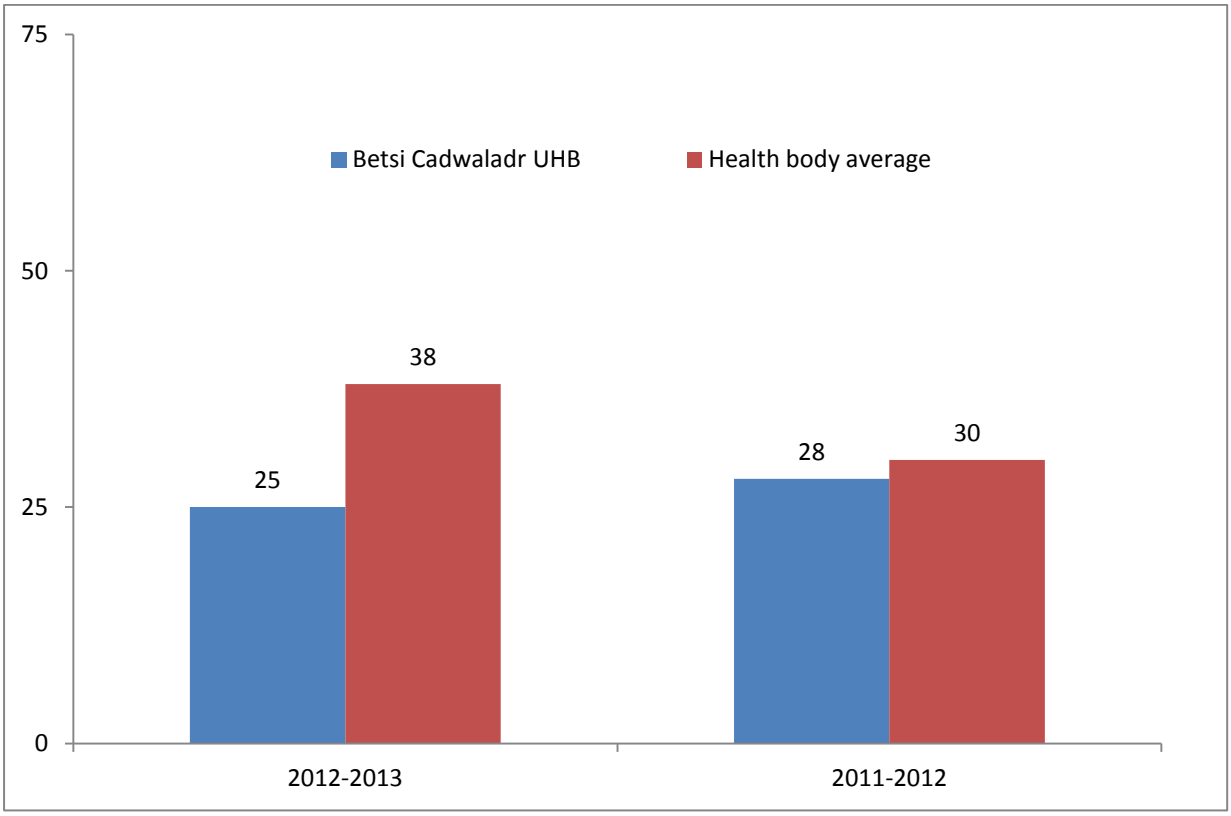
2011-2012



D: Complaints taken into investigation by my office

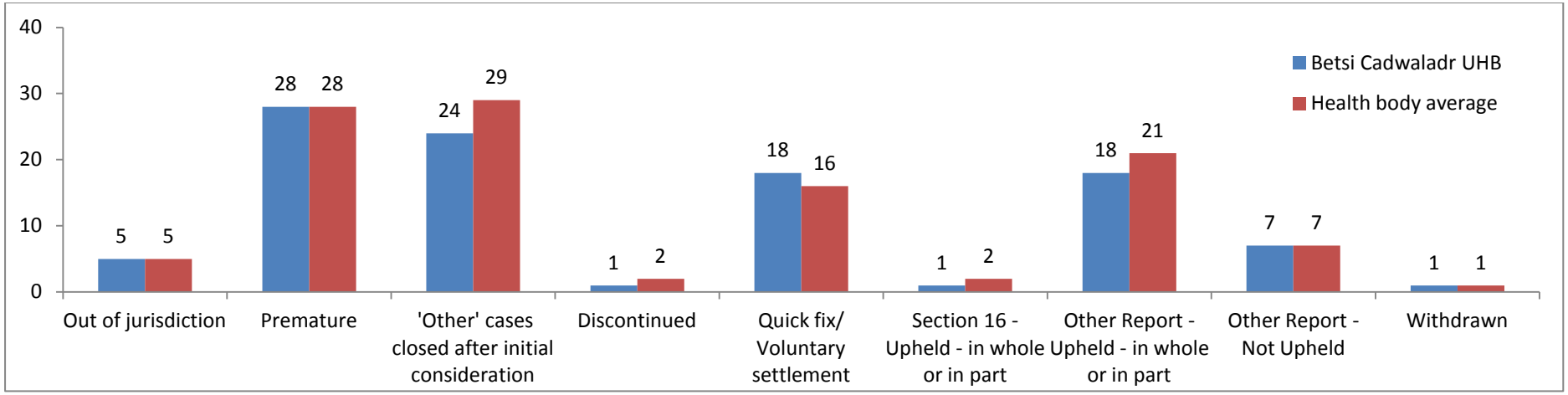
	2012-2013	2011-2012
Number of complaints taken into investigation	25	28

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

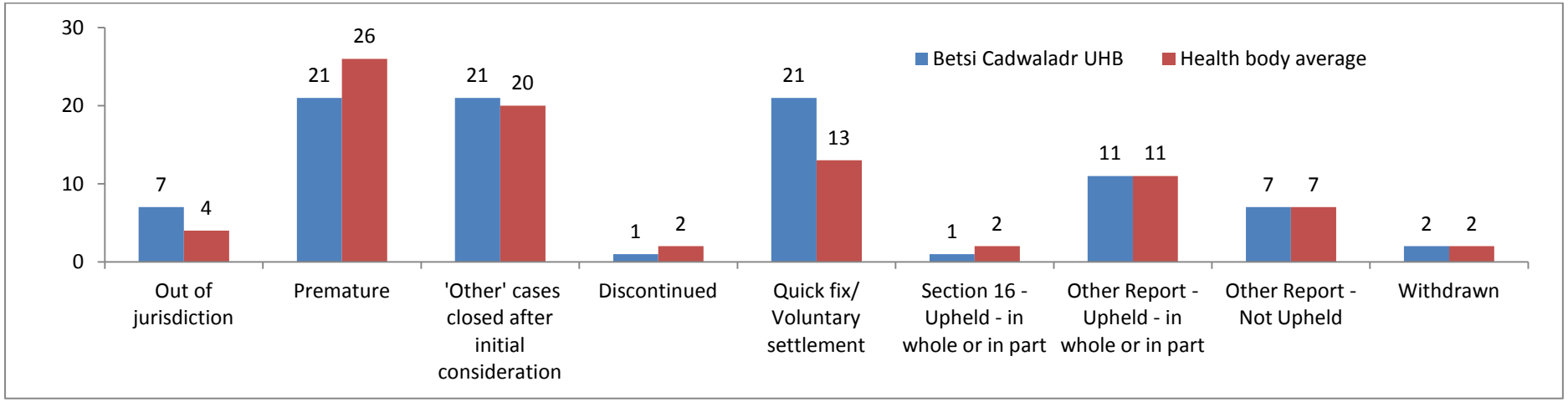


F: Comparison of complaint outcomes with average outcomes for health bodies, adjusted for population distribution

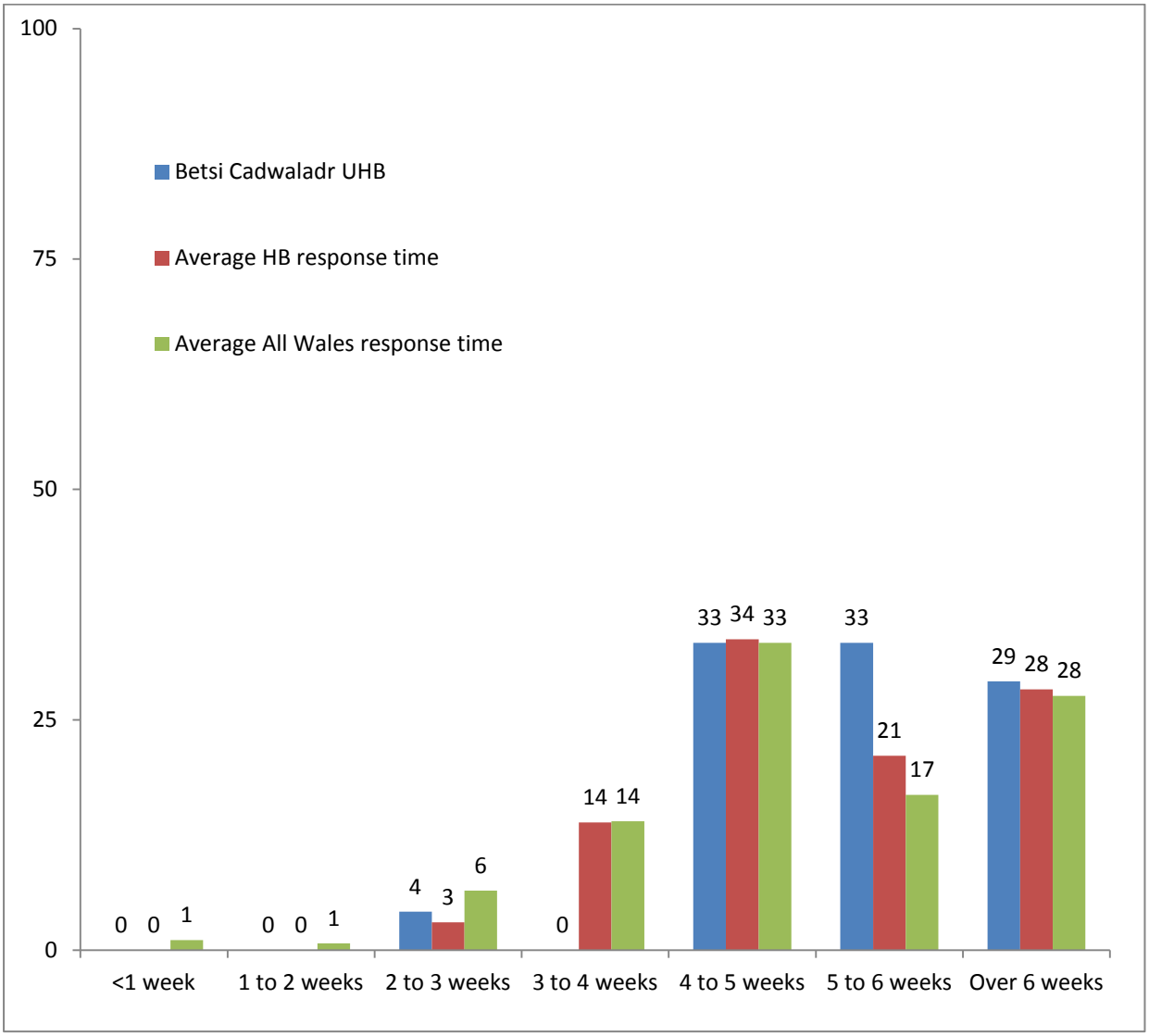
2012-2013



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

August 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs A complained about the care given to her late father, Mr Y, when a patient at Glan Clwyd hospital in 2009. She said that there were delays in his diagnosis and treatment. Sadly Mr Y died on 7 November 2009 following extensive surgery to drain a perianal abscess and treat the quickly progressing and very serious infection which developed.

The Ombudsman upheld Mrs A's complaint. He found that delay in diagnosis and in carrying out surgery were significant factors in
Mr Y's death. His main findings were:

- lack of review by a consultant urologist
- failure by doctors to record consistently and act upon significant test results to review the initial diagnosis
- poor communication between medical staff and with the family. There were missed opportunities to obtain information from the family, given that Mr Y had Alzheimer's disease and communication difficulties
- no overall plan of nursing care for Mr Y and a failure to reassess as his condition deteriorated
- a criticism of the decision not to carry out surgery late at night and the lack of direct dialogue between the consultant anaesthetist and consultant surgeon.

The Health Board agreed to make a payment of £3,000 for the trauma caused to the family for the distressing way in which Mr Y died and the knowledge that the delays contributed to the sad outcome. The Ombudsman made a range of recommendations for the review of procedures, audit and training His recommendations were accepted by the University Health Board.
Case reference 201101271

Other reports - Upheld

March 2013 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs Y complained about the care and treatment provided to her, specifically that she underwent three unsuccessful procedures for hiatus hernia and was of the view that she should have been referred to a sub specialist sooner. She also raised concern that these procedures may have hampered the open surgery she later received and may mean that further surgery can't be an option for her. Mrs Y also complained about the delay by the Health Board in responding to her letter of complaint and said that the reply didn't fully address the issues she had raised.

In considering the complaint the Ombudsman took advice from one of his independent clinical Advisers, a Consultant Surgeon. The Ombudsman found that the care and treatment that Mrs Y received was in many respects reasonable. He agreed that the First Surgeon was sufficiently specialist to deal with Mrs Y's condition and noted that the procedure was not certain to work as the failure rate is generally quite high. He was also clear that Mrs Y had received the appropriate tests throughout her care and treatment and in the main Mrs Y had received appropriate and timely clinical review at outpatient appointments.

However, the Ombudsman did identify one significant concern. He was of the view that after the Second operation a second opinion from a colleague should have been sought or that a colleague with similar or greater experience should have helped at the third operation. He also made some criticism of the fact that Mrs Y was not reviewed at one point in line with the plan as there had been a sickness absence. He was also concerned that the period leading up to the Third operation was elongated and that there was no record to indicate that this was a planned course of action.

The Ombudsman could not be definite that the care Mrs Y received, particularly the number of procedures performed, actually caused Mrs Y unnecessary suffering as it cannot be known what the outcome might have been if she had received a second opinion before or at the time of the Third operation. However, as a result of this uncertainty he was of the view that there has been some injustice to Mrs Y.

The Ombudsman also raised concern about the delay in the Health Board's response and its limited reply to some of the concerns. He was particularly concerned that the shortcomings had not been fully recognised. The Ombudsman partially upheld the complaint and recommended that the Health Board issued an apology to Mrs Y and provided a redress payment of £750 in recognition of the time and trouble incurred and the uncertainty remaining for Mrs Y. He also recommended that the Health Board ensure that proper arrangements are in place for obtaining second opinion in circumstances such as these in future.

Case reference 201201047

February 2013 – Clinical treatment outside hospital – Betsi Cadwaladr University Health Board

Mrs A complained about the care and treatment provided to her by an out-of-hours GP service based at a hospital in the area of Betsi Cadwaldr University Health

Board. Mrs A was six months pregnant when she presented at the GP service with abdominal pain and urinary symptoms. A diagnosis was made of a urinary tract infection and she was discharged home. On that same day, Mrs A was readmitted to hospital and gave birth to her twins. Sadly, both babies died two days later.

The Ombudsman found that the consultation fell short of the standard of care expected of the GP service and that the action taken and diagnosis made was not reasonable in light of Mrs A's symptoms. On this basis, the complaint was upheld. However, the Ombudsman was unable to say with any certainty that, but for these failings, the premature birth of Mrs A's twins would have been prevented.

The Ombudsman recommended that the Health Board should provide an apology to Mrs A for these shortcomings together with a payment for £3000 in recognition of the distress caused.

Case reference 201200526

January 2013 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs D complained about aspects of the care provided to her late husband, Mr D, whilst in a hospital managed by the Health Board. Mr D died in hospital after a short stay. Mrs D said that the hospital delayed administering antibiotics to Mr D on admission, communicated poorly, left Mr D in an undignified state on transfer to another ward, failed to send his medical notes with him on transfer and responded slowly to her complaints about these issues.

The Ombudsman upheld all of Mrs D's complaints, at least to an extent. However, he did not conclude that the failures contributed to the sad outcome. He also criticised the hospital for its management of Mr D's steroid administration.

The Ombudsman made numerous recommendations. These included paying £650 to Mrs D as an acknowledgement of her injustice and for her time and trouble pursuing the complaints, various reminders to medical staff and that it should inform him about current complaint response timeliness. The Health Board accepted the recommendations.

Case reference 201201063

November 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr A complained about the care of his late grandmother, who was elderly and diabetic. He said that there were errors relating to her admission and discharge and poor medical and nursing care. Record keeping was also poor.

The Ombudsman found that the appropriate documentation was not completed in respect of Mr A's grandmother's skin integrity on admission to Glan Clwyd hospital. He upheld that part of Mr A's complaint. But both doctors and nursing staff noted a pressure ulcer the following day and the appropriate care was given to reduce the risk of developing further pressure sores. He was also critical that a cannula had been wrongly inserted and found that there had been a lack of appropriate recording and response to the incident by the Health Board. The Ombudsman was also critical that medical record keeping for Mr A's grandmother's stay in Prestatyn Community

hospital did not meet the accepted standard. The Health Board agreed to apologise to Mr A and to make a payment of £250 for his time and trouble in making the complaint. It also agreed to remind staff of the importance of record keeping and to review its policy on the insertion/removal of cannula.

Case reference 201103032

November 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr H complained to the Ombudsman about a failure by Health Board staff to ensure that he was catheterised during an operation to remove his appendix. He was concerned that clinical staff failed to record his wish to be catheterised before the operation. Mr H complained that as a result of this failure, his bladder was damaged as a result of excessive urine retention. Mr H was also unhappy with the manner in which the Health Board investigated his concerns.

The Ombudsman found that there would have been no need for Mr H to have been catheterised during his operation and that even if his request had been recorded this should not have resulted in this happening. Therefore this aspect of the complaint was upheld. However two aspects of his concerns about complaint handling, namely a delay in responding to Mr H's concern and a failure to identify staff who had made entries in his clinical notes were upheld. As a result the Ombudsman recommended that the Health Board apologises to Mr H and that it reminds staff of the need to sign clinical entries.

Case reference 201200659

November 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs D complained about Betsi Cadwaladr University Health Board ("the Health Board"). Mrs D fell whilst an inpatient at Glan Clwyd Hospital aged 91. She stated that the fall occurred in the middle of the night when she was "bullied" into walking to the toilet, with the help of the attending nurse, rather than being allowed to use a commode. She also had concerns about how the wound, caused by the fall, was treated.

The Ombudsman could not uphold Mrs D's complaint about the fall despite acknowledging that the fall and its aftermath were very distressing for Mrs D. He found that there was conflicting evidence about when the fall occurred. Moreover, he concluded that the falls risk assessment was adequate in relation to Mrs D and indicated that she could walk to the toilet with appropriate assistance. The Ombudsman explained that mobilisation for patients is important and there was nothing to demonstrate that the professional judgement of the nurse was wrong in encouraging Mrs D to walk. The Ombudsman concluded that the response of the nurse to the incident and investigation was sound. In relation to wound care, the Ombudsman did not find specific fault but noted that infection control techniques were not recorded fully. Therefore, as Mrs D did acquire an infection in the wound, he upheld the complaint to the extent that there was doubt about the care. The Ombudsman also noted some problems with the local resolution response to Mrs D's original complaint to the Health Board.

The Ombudsman recommended that the Health Board pay Mrs D £300 for the injustice she suffered about the wound care and to reflect inadequacies in complaint handling.

Case reference 201200819

October 2012 – Other – Betsi Cadwaladr University Health Board & Isle of Anglesey County Council

Ms A complained on behalf of her mother, Mrs B, and her uncle, Mr W, about the care and treatment provided to Mr W by the Isle of Anglesey County Council and Betsi Cadwaladr University Health Board. In particular, Ms A complained about the lack of communciation with the family, specifically with her mother during Mr W's stay a nursing home from July 2008 to February 2011, and following his admission to hospital on 21 February 2011.

The Ombudsman partly upheld the complaint. Having sought advice from a registered social worker, a registered mental health nurse and consultant psychiatrist, the investigation found that the level of communication with the family regarding Mr W's care was inadequate. Shortcomings in the Health Board's care and aftercare planning and in its record keeping were identified, in addition to a failure to respond to the initial complaint. Inadequacies in the Council's complaints handling and in its complaints policy were also highlighted.

The Ombudsman made a number of recommendations to address the failings identified, including that the Health Board and Council should apologise for the communication failings and agree that a joint response to such complaints will be provided in future cases. The Ombudsman also recommended that the Health Board should make a redress payment of £300 to the family for the failure to respond to the complaint, and take appropriate action to address any failings with regard to the Care Programme Approach.

Case reference 201101477 & 201101445

September 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs R complained about the care provided to her mother, Mrs G, at Glan Clwyd Hospital in April 2011 and at Colwyn Bay Community Hospital during April – May 2011. Mrs R was also concerned about Betsi Cadwaladr University Local Health Board's response to her complaint; in particular that it did not contact her mother's care home for information.

The Ombudsman found that the standard of care was broadly reasonable, albeit he was unable to determine whether some bruising suffered by Mrs G occurred in hospital or later on. The Ombudsman considered that the communication surrounding Mrs G's transfer between the hospitals fell below a reasonable standard, as did pressure area care and prevention in relation to Mrs G's heel. To the extent of these failings the Ombudsman upheld this part of the complaint. He also criticised some aspects of the way the Health Board dealt with Mrs R's complaint.

The Ombudsman recommended that the Health Board should apologise to Mrs R for the failings he identified. He also recommended that relevant staff be reminded of

the need for good communication with family members when a patient is transferred, and of relevant guidance about the prevention and treatment of pressure sores.
Case reference 201102797

August 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mrs A complained about the treatment that Mr B received during his stay in Glan Clwyd Hospital ("GCH") between 29 January and 7 February 2011. Mr B had a history of cardiac problems and was taking a range of medication, including Warfarin. On admission Mr B was diagnosed with acute cholecystitis. Mrs A questioned why a CT scan was not requested or performed; why a cholecystectomy was not performed and, why, if his treatment was appropriate during the first admission, did Mr B have to be readmitted on 9 February. Mrs A also said that she was not satisfied with the report of the investigation carried out by Betsi Cadwaladr University Health Board ("the UHB") into the complaint that she made to it about the matter.

The Ombudsman's investigation considered whether Mr B's treatment during the first admission was appropriate; whether he was discharged too early and whether the UHB responded appropriately to Mrs A's complaint. The Ombudsman obtained independent professional advice from a Consultant General Surgeon and an experienced Ward Sister. The investigation concluded that the decision to treat Mr B conservatively during the first admission was clinically appropriate. However, there were unacceptable record-keeping failures by both clinical and nursing staff. Those failures impacted on the ability to reach a definitive conclusion on whether the lack of a CT scan during the first admission affected the decision to discharge Mr B. They also impacted on the ability to reach a definitive conclusion on whether the UHB's discharge policy was followed.

The Ombudsman partly upheld Mrs A's complaint and recommended that the UHB provide both Mrs A and Mr B with a clearly worded written apology for the failings identified by this investigation and also that it should provide training to the nursing and clinical staff involved in Mr B's care on the NMC guidance and the RCP Standards on record keeping.
Case reference 201101609

August 2012 – Appointments/admissions/discharge/transfer procedures – Betsi Cadwaladr University Health Board
Mr A complained that as a result of having to wait for a total knee replacement to be carried out by the Health Board, he had to pay for private treatment. He said that the Health Board had failed to give him appropriate information about the waiting list and it should therefore reimburse the cost of his private treatment. Mr A also said that, when he complained, he received inconsistent and confusing answers from the Health Board.

The investigation considered whether the Health Board had properly implemented the Welsh Government Guidance "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules"), and whether it had dealt with his complaint properly.

The crux of Mr A's complaint was that the Health Board's administration of the RTT Rules was unfair and the Health Board should therefore reimburse the cost of his private treatment. The investigation concluded that there was no detrimental error in the application of the RTT Rules. This part of the complaint was not upheld. The investigation identified that the Health Board missed clear opportunities to give Mr A definitive responses to the questions he raised. It could also have provided him with a much earlier decision about whether it intended to reimburse his costs. The Health Board's letters contained too much jargon and assumed that Mr A was familiar with procedural terms that were included. This part of Mr A's complaint was upheld.

The Ombudsman recommended that the Health Board apologise to Mr A for the unnecessary length of time it took to deal with his complaint and for failing to provide clear information when responding to his complaint. Recommendations were also made on training of medical and administrative staff involved in responding to complaints and staff involved in the administration and management of waiting lists. The Health Board agreed to implement the recommendations.
Case reference 201103800

August 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mrs J had a number of concerns about the treatment her late mother ("Mrs B") received at the Wrexham Maelor Hospital ("the Hospital"). Mrs B had been admitted following a fracture to her hip and upper arm, but, sadly, died four weeks later after suffering a perforated duodenal ulcer. Mrs J complained about failures to investigate and so diagnose her mother's ulcer, the standard of nursing care, failing to provide her mother with adequate pain relief and palliative care. She also complained that the UHB had delayed in responding to her complaints.

The investigation found that examinations of Mrs B had found no signs to suggest she had a perforated ulcer, and neither had an X-ray revealed any of the usual associated symptoms. Therefore, even with hindsight, it was not possible to say when the perforation happened. This element of the complaint was not upheld. Sadly, Mrs B was too unwell to undergo surgery. Whilst a decision was taken to provide her with palliative care, the necessary end of life pathway documentation was not completed properly, so she received inadequate end of life pain relief. This part of the complaint was upheld. However, the Ombudsman's nursing adviser felt that, overall, the nursing care delivered to Mrs B was of a "high standard". This part of the complaint was not upheld. The UHB's handling of Mrs J's complaint was found to be "unacceptable", so this concern was upheld.

The Ombudsman recommended that the UHB apologise to Mrs J for the failings identified and complete a review into its palliative care delivery. It should produce an action plan to include ensuring the proper completion of associated documentation in future. The UHB agreed to the recommendations.
Case reference 201100933

June 2012 – Appointments/admissions/discharge and transfer procedures – Betsi Cadwaladr University Health Board

Mrs M's father, Mr P was admitted to Ysbyty Gwynedd Hospital ("the Hospital") on 2 December 2009 to remove a cancerous tumour. Following the operation Mr P remained in the Hospital until 25 March 2010 when he was transferred to a rehabilitation hospital but sadly died on the 27 March 2010. Mrs M's complaint concerns the care and treatment that her late father received post operatively whilst an inpatient at the Hospital. In particular she was dissatisfied with the decision to transfer Mr P to the rehabilitation hospital whilst he had pneumonia; especially given that he was drowsy on the morning of the transfer. Mrs M expressed concern that by transferring her father in a passenger ambulance in his pyjamas and dressing gown his dignity was not respected. Mrs M also had other concerns about her father's management including the prolonged use of antibiotics during Mr P's treatment and the poor communication she experienced during her father's stay in the Hospital. Finally, she complained about the way the Health Board dealt with her complaint.

The Ombudsman's investigation concluded that the care and treatment that Mr P received was reasonable and appropriate and that in the context of ambulance transfer Mr P's attire was reasonable. Mrs M's complaint was therefore not upheld. Given Mr P had a number of pre-existing illnesses including poor heart and renal functions and given his frailty, the Ombudsman said that it would have been more appropriate to have transferred Mr P in a stretcher ambulance where he could have been appropriately cared for during the ambulance journey. To that extent Mrs M's complaint was upheld.

The Ombudsman concluded that the Health Board's delay in addressing Mrs M's complaint was unreasonable and her complaint was upheld. The Health Board was asked to consider, from a complaints handling perspective, what lessons can be learnt from this case particularly when communicating with relatives who do not reside locally.

Amongst the recommendations the Ombudsman made was that the Health Board apologise to Mrs M and her mother for the failings in communication and complaint-handling identified by the investigations, and should pay Mrs M £250 in recognition of the distress and frustration that the delay and inadequacy of its response had caused her.

Finally, the Health Board was asked to remind staff on the ward that when a patient needs to be transferred their clinical needs, age, frailty and any other relevant factors should be considered to ensure the most appropriate mode of transport is provided. The comments of the Ombudsman's advisers on this particular aspect should be shared with those that were involved in Mr P's care and evidence of this should be provided to Mrs M and this office.

Case reference 201100947

June 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs A complained about the care provided for her late mother, Mrs B, by the former North Wales NHS Trust ('the Trust'). She reported that the Trust's management of Mrs B's hysterectomy, pressure ulcers, leg wounds and personal hygiene needs had

been inadequate. She implied that Mrs B's hysterectomy had been unnecessary. She indicated that the nutritional, critical and palliative care provided for Mrs B, by the Trust, had been lacking. She noted that she was dissatisfied with the Trust's infection control. She suggested that the Trust had removed a bed, prescribed for Mrs B, improperly. She complained that some staff members had been "uncaring and unhelpful."

The Ombudsman did not make a finding regarding the infection control element of Mrs A's complaint. He partly upheld the other aspects of it. He recommended that Betsi Cadwaladr University Health Board ('the Health Board') should apologise, in writing to Mrs A, for its failings. He asked it to share the clinical issues identified with all relevant staff members on a formal basis. He noted that it should, when doing this, pay particular attention to its failure to comply with relevant guidelines, a medication reference book and its nutrition policy. He also asked it to highlight, when sharing these issues, a diagnostic concern and the importance of reviewing urgent x-rays on the day of their occurrence. He recommended that it should undertake a training audit to ensure that staff members have been, or are, trained to complete repositioning schedules and risk assessment forms for pressure ulcers correctly. The Health Board agreed to comply with all of these recommendations.
Case reference 201100437

June 2012 – Clinical treatment outside hospital – Betsi Cadwaladr University Health Board & Isle of Anglesey County Council
Mr and Mrs A complained about the care and treatment provided to Mrs A's brother, Mr H, and the failure of the Health Board to deal adequately with their complaint.

In May 2009, Mr H was sectioned and detained at a local Psychiatric Unit. This followed concerns that Mr and Mrs A raised about Mr H not eating or drinking properly and neglecting himself. Mr H was diagnosed as having a severe depressive illness with psychotic symptoms. On receiving treatment his condition improved and he was discharged in July 2009.

Prior to leaving hospital, Mr H was placed on an enhanced care programme approach ("CPA"). The enhanced CPA is meant to reflect the fact that the individual requires greater intervention and a more comprehensive care plan in place to minimise the likelihood of relapse when they are back in the community. To help co-ordinate Mr H's care, a Social Worker ("the SW") from the Community Mental Health Team ("CMHT"), which consists of health and social services professionals, was appointed as Mr H's Care Co-ordinator. A key part of Mr H's care plan was that he would have regular visits from the SW. Following three home visits to Mr H (in July and September), the SW's subsequent contact with Mr H were telephone calls. Following the SW's periods of illness, social work contact appears to have lapsed, although Mr H continued to attend his outpatient appointments with his Psychiatrist. In March 2010, following concerns raised by a neighbour, Mr H was found dead at home. The post-mortem findings found that he had died of a pulmonary embolism (where blood clots cause blockages of the blood vessels in the lungs) due to deep vein thrombosis.

The Ombudsman's investigation found evidence of systemic failings in the operation of the CMHT. Poor management controls had adversely affected how council staff,

including the SW, operated within the CMHT. There was also a failure to take a cohesive multi-disciplinary approach to changes in Mr H's care plan. The Ombudsman's investigation concurred with a previous Health Board investigation that inadequate mechanisms were in place to ensure effective follow up of clients, such as Mr H, during the prolonged absence of the SW. Whilst the Ombudsman did not identify any issues with the clinical care provided to Mr H following his discharge, nevertheless, the Ombudsman had concerns about how effectively the health professionals and social workers within the CMHT had worked together to ensure that Mr H received co-ordinated care. In view of the shortcomings identified, the Ombudsman upheld Mr and Mrs A's complaint against the Council.

The Ombudsman was highly critical of the way that the Health Board had dealt with Mr and Mrs A's complaint. He highlighted inadequacies in the then Chief Executive's response to Mr and Mrs A. Of particular concern was that corporately the Health Board had compromised its ability to learn lessons from Mr and Mrs A's complaint by its approach of removing references to shortcomings (identified during the joint investigation between the Health Board and the Council), from the complaint response. As a consequence, Mr and Mrs A's concerns had not been properly addressed. The inadequacies in the Health Board's complaints handling process led the Ombudsman to uphold this aspect of Mr and Mrs A's complaint.

Amongst the Ombudsman's recommendations was that both the Council and the Health Board's Acting Chief Executives should apologise for the failings identified. In addition, recommendations were made to address the Health Board's poor complaints handling. This included the Health Board paying Mr and Mrs A redress of £500 to reflect the inconvenience caused to them as a result of the Health Board's failings.

The Ombudsman also recommended that both the Council and the Health Board should jointly identify any further lessons that could be learnt from this report and develop an action plan. Finally, the Ombudsman recommended that the Council and the Health Board develop a procedure for dealing with self-neglect cases.
Case reference 201100506 & 201100509

May 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mrs Z complained about the standard of treatment provided to her during the birth of her child by caesarean section. Specifically she complained that the procedure was lengthy and difficult and that the registrar performing the surgery was overtly anxious and needed to telephone the consultant on call for advice part way through the procedure. Mrs Z said that this had caused her significant distress both during the procedure and subsequently.

The Ombudsman's clinical adviser noted that the delivery had been difficult because of the transverse position of the baby. However, the medical care provided by the registrar was of a good standard and she had acted appropriately in seeking assistance and advice. It was regrettable that the registrar had displayed her anxiety in the manner that she did. The registrar had apologised for her behaviour at the time. The consultant had also spoken to Mrs Z and offered an apology. The Health Board had acknowledged that such behaviour was unacceptable and confirmed that

the registrar had undergone additional work-based reflection and assessment to ensure that this did not recur. The Ombudsman felt that there was no additional action that the Health Board could have taken to respond to the complaint. However, the Ombudsman did note that there had been a lengthy delay in the complaints process which had been unhelpful in trying to resolve matters for Mrs Z. He recommended that the Health Board make a payment of £100 to Mrs Z to reflect this.
Case reference 201102187

May 2012 – Continuing Care – Betsi Cadwaladr University Health Board
Mrs R complained about the arrangements for her late mother's discharge from hospital, and in particular, that the Health Board failed to follow the proper process for determining whether her mother was eligible for NHS continuing care funding. She also complained that the Health Board did not properly involve the family in decisions and that communication with family members was poor. Finally, Mrs R was dissatisfied with how the Health Board dealt with her complaint.

The Ombudsman found that while there was evidence of maladministration in how the Health Board determined whether Mrs R's mother was eligible for continuing care funding, which did not cause her an injustice as the outcome would have been the same. The Ombudsman only upheld this part of the complaint to the extent that a proper explanation for the decision was not provided to the family.

The Ombudsman did not uphold the complaint about the involvement of, and communication with, family members as circumstances outside the Health Board's control made this difficult. The Ombudsman upheld the complaint about how the Health Board dealt with the complaint to the extent that there were some delays; however, the responses provided were adequate.

The Ombudsman recommended that the Health Board apologise to Mrs R for the failings identified and made some procedural recommendations. These were accepted by the Health Board.
Case reference 201100883

April 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mr B complained about the care and treatment provided to his mother, Mrs B at Wrexham Maelor Hospital. In particular, he complained that:

1. Mrs B had not received adequate nourishment and hydration for several weeks.
2. Mrs. B was subjected to unnecessary investigations into her condition, particularly that staff took unnecessary blood tests which caused her distress.
3. Mrs B's clinicians sought to withdraw treatment from her.
4. Mrs B's fingernails and toenails had not been cared for.
5. Two members of nursing staff did not attend to Mrs B's needs during the evening of 5 November.

The Ombudsman's investigation found that there was no evidence that a care plan was completed in respect of Mrs B's hygiene needs. This was inadequate. However Mr B's further complaints were not upheld.

Amongst the recommendations made were that Betsi Cadwaladr University Health Board should offer Mr B an apology for the failing identified in the care of Mrs B's hygiene needs. It was also recommended that it should remind staff of the need for comprehensive care planning, of their obligations to ensure that documentation is correctly completed in a timely manner and that it is not appropriate for any concerns or complaints to be documented in the patient's medical records.

Betsi Cadwaladr University Health Board was asked to note the comments of the Ombudsman's renal adviser that the involvement of more senior staff in attempting intravenous access may have been appropriate. Betsi Cadwaladr University Health Board accepted the Ombudsman's recommendations.
Case reference 201002631

April 2012 – Appointments/admissions/discharge & transfer procedures – Betsi Cadwaladr University Health Board
Mr J complained that Betsi Cadwaladr University Local Health Board refused to consider him for endovenous laser ablation treatment for his varicose veins on the basis of where he lives. This treatment involves a laser being inserted into a vein and drawn along, heating the vein up and sealing it closed.

The Ombudsman found that the Health Board only offered this particular treatment to patients living in the local area of the hospital that provided it. Patients who lived outside this area were not accepted for the treatment solely on the basis of where they lived. Mr J's GP had, in her referral letter, given reasons why Mr J wished to be treated at the hospital concerned. There is no evidence that these reasons were given any consideration before the referral was rejected.

The Ombudsman found that the Health Board was acting inequitably by restricting the treatment on a strict geographical basis rather than clinical need. He also found that the Health Board had fettered its discretion by not considering whether the reasons given in the referral letter would justify Mr J receiving the treatment on an exceptional basis. The Ombudsman upheld the complaint. He recommended that the Health Board should apologise to Mr J, revise its policy on the provision of endovenous laser ablation treatment so that any restrictions are based on clinical need rather than where in its area the patient lives, and reconsider Mr J's referral against this new policy. The Health Board agreed to implement the recommendations.
Case reference 201101616

Other reports - Not Upheld

February 2013 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mrs A complained that the right knee implant, inserted by Conwy and Denbighshire NHS Trust ("the First Trust"), was too big for her. She said that the First Trust and the North Wales NHS Trust ("the Second Trust") did not identify this error during her follow-up orthopaedic appointments. She suggested that they also failed to recognise that she had an infection, related to this implant, during these appointments. She told us that she had experienced, and continued to experience, unnecessary suffering and limited mobility because of these failings. She indicated that she was dissatisfied with Betsi Cadwaladr University Health Board's ("the Health Board's") response to her complaint about this matter.

Having taken clinical advice, the Ombudsman did not consider that the knee implant, inserted by the First Trust, was too large for Mrs A. Nor did he consider that the follow-up orthopaedic care, provided by the First and Second Trusts, was flawed. The Ombudsman therefore concluded that the Health Board's response to Mrs A's complaint was reasonable and he did not uphold the complaint

Case reference 201200780

January 2013 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr R attended Glan Clwyd hospital A&E, he was x-rayed and diagnosed as having soft tissue injury to his ankle. Mr R later attended Wrexham Maelor hospital, his request for another x-ray was denied and adviced to attend Glan Clwyd. Mr R was reviewed at Glan Clwyd and told that he had soft tissue injury. Mr R's pain continued, he telephoned and was told to attend Dr C's clinic. Mr R attended and was told there was no clinic and to attend A&E, there a Triage nurse said that Dr C would not be overruled and that he would have to wait 3 ½ hours. Because of the pain, he left and saw his GP who referred him for private treatment that revealed three fractures and dislocated ligaments which necessitated surgery, funded by Mr R. He complained that his injury should have been identified and he should have had another x-ray.

The Adviser found that Mr R's management was to a reasonable standard and he had no criticism of the treatment at A&E departments. He reviewed the initial x-ray, and said it was reasonable not to have carried out another x-ray. The hospital Consultant apologised that Mr R was erroneously told to attend the clinic and the Health Board apologised for the Triage Nurse's failure to assess Mr R. The Adviser reviewed the privately subsequently taken x-ray and opined that it revealed opacities not apparent on the original x-ray and he reiterated that treatment following the initial x-ray had been to a reasonasble standard. The complaint was not upheld.

Case reference 201102113

September 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Ms A's complaint concerns the care and treatment provided to her late grandfather by the A&E department at Wrexham Maelor Hospital ("the Hospital"). In particular, she remained dissatisfied with the Emergency Medicine Consultant's ("the

Consultant") decision to discharge her grandfather on 5 January and the subsequent delay in carrying out an emergency operation for perforated duodenal ulcer following her grandfather's admission to the Hospital on 7 January.

The Ombudsman's investigation concluded that Ms A's grandfather's discharge on 5 January 2011 was reasonable and appropriate. However, the Ombudsman identified lessons that could be learnt from this complaint and invited the Health Board to carry out various proposals including:

- an anonymised review of Ms A's grandfather's case (as part of an After Action Review or multidisciplinary Clinical Governance / morbidity and mortality meeting), to highlight: (a) the wider aspects of the care of an elderly patient with abdominal pain, (b) the potential benefit of greater integration of primary and secondary care for such patients. Following this meeting the Health Board should consider providing an action plan of any lessons learnt from your grandfather's case. The action plan should include pertinent timescales, measurable outcomes and details of how it intends to disseminate the outcomes to clinical staff.

- through a clinical lead, reinforce at a consultants' forum the need to comply with the General Medical Council and the Royal College of Physician's guidance on writing clinical progress notes, with the outcome disseminated at a junior teaching session.

Case reference 201103050

August 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr R complained about the standard of care provided to his late mother, Mrs R, whist she was an inpatient at Ysbyty Gwynedd. Mrs R was admitted to hospital due to DVT and Pulmonary Embolism and was given warfarin treatment. However, she suffered warfarin-induced skin necrosis as a result. Whilst this was recognised by clinical staff, it was not possible to reverse the damage and Mrs R had to undergo an operation to amputate her right toes. Mrs R was also suffering from duodenal cancer and Mr R complained that clinical staff had failed to promptly diagnose and treat her illness. Mrs R sadly died several months later.

The Ombudsman sought clinical advice on Mr R's complaint. The adviser's view was that clinicians had appropriately monitored Mrs R's warfarin level. The diagnosis of warfarin-induced skin necrosis was not clear but, once it was considered likely, the warfarin treatment was stopped and appropriate attempts made to reverse its effects. In relation to the diagnosis and treatment for her cancer, the adviser noted that this was a complex case. The adviser's view was that clinicians appropriately pursued the diagnosis and treated Mrs R's symptoms. The adviser was unable to identify any clear variance between the care that was delivered and that which would be expected. The difficulty in diagnosing Mrs R's condition, which had understandably caused concern to the family, was related to the complexity of her condition and presentation rather than any deficit in the standard of the care provided to her. On the basis of the advice received, the Ombudsman concluded that the care provided was of a good standard and did not uphold the complaint.

Case reference 201102920

June 2012 – Clinical treatment outside hospital - Betsi Cadwaladr University Health Board area
Ms Z complained about the standard of care and treatment provided in respect of her mental health over a number of years. Ms Z said that she had been diagnosed with bipolar disorder and borderline personality disorder and been treated for these conditions. She had been receiving support from the Community Mental Health Team but she was eventually discharged. Ms Z was aggrieved the clinicians withdrew support when she needed it, and that as a person with obvious mental health issues she had been treated poorly. Ms Z was also aggrieved with the Health Board's response to her complaints about these, and related, issues.

The investigation found that the care and treatment provided to Ms Z had been of a reasonable standard. The investigation found that the re-evaluations of her care and the decisions taken to discharge her also appeared to have been reasonable. The investigation also found that the Health Board had responded reasonably to the complaints made to it by Ms Z. The complaint was therefore not upheld.
Case reference 201100635

June 2012 – GP in Betsi Cadwaladr University Health Board area & Betsi Cadwaladr UHB
Ms P's complaint concerns the care provided to her grandfather Mr P by his General Practitioners Dr M and Dr C between 22 December 2010 and 6 January 2011 when he presented with abdominal pain. She also complained about the Out of Hours GP Care that her grandfather received on 2 and 6 January 2011.

The Ombudsman's investigation concluded that the care provided to Mr P was entirely reasonable and appropriate. However, the Ombudsman's Adviser highlighted that in Mr P's consultation on 22 December with Dr M, Dr M had not fully explored Mr P's history, in particular, the nature and chronology of his abdominal pain. This was coupled with a failure to carry out an internal examination. The Ombudsman considered that these failings amounted to a shortcoming in the treatment Mr P received and was not in compliance with the General Medical Council's guidance. He invited Dr M to reflect on the consultation and identify what lessons could be learnt from this.

The Ombudsman was satisfied from the evidence that he had seen and the advice that he received from his GP Adviser that whilst an internal examination would have been useful it would not have altered the outcome for Mr P. Ms P's complaints against Dr M and Dr C were therefore not upheld.

In relation to Ms P's concerns about the Out of Hours GP Care's management of Mr P, the Ombudsman was satisfied that the care provided to Mr P on 2 and 7 January was reasonable and therefore Ms P's complaint was not upheld.
Case reference 201102431, 201102554 & 201103051

May 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board & GP practice in Betsi Cadwaladr UHB area
Mrs A complained via her advocate at the Community Health Council about the treatment that her late husband, Mr A, received from the Health Board's Maelor Hospital (" the Hospital"), where he had been referred by his GP Practice with

symptoms that included a severe headache. Mr A, who was admitted overnight, had various investigative tests carried out including a D-dimer test which produced a positive result and which the advocate noted to be a diagnostic test for deep vein thrombosis ("DVT"). Mr A was discharged on 9 February 2010, following a diagnosis of a tension headache. Mr A continued to attend at the Practice. During consultations with a Dr C at the GP Practice, Mrs A said that Mr C had been made aware of Mr A's painful and swollen right leg which, along with tightness in his chest, had caused Mr A to be increasingly immobile. Sadly, Mr A died at home as a result of DVT on 27 February 2010. Mrs A felt that in the weeks leading up to Mr A's death, there were sufficient indicators (including his previous history of DVT), which had they been acted on, would have led to Mr A's DVT being diagnosed earlier. Mrs A was dissatisfied with the Independent Complaints Secretariat's ("ICS") earlier findings on her complaint.

In relation to the Health Board, like the ICS, the Ombudsman's investigation found that given that Mr A's presenting symptoms (at the time of his hospital admission) were not suggestive of DVT, the D-dimer test should not have been carried out. For this reason it would not have been clinically appropriate to have had regard to the test results since factors other than DVT can produce a positive result. The Ombudsman noted that there had clearly been failings within the Health Board that had led to the D-dimer test being requested in the first place.

The Ombudsman having considered the advice provided by his clinical advisers concluded that the level of care that the Health Board and Dr C at the Practice had provided to Mr A was reasonable and therefore he did not uphold Mrs A's complaint.
Case reference 201100803 & 201102640

Quick Fixes & Voluntary Settlements

March 2013 – Other – Betsi Cadwaladr University Health Board
Mr C made a complaint to the Health Board in April 2012, regarding an operation that was carried out at Bangor Hospital. On 14 June 2012, Mr C was informed that his complaint had been passed to the Health Board's Surgical & Dental Clinical Programme Group, which was in the process of finalising its investigation into his complaint. However, Mr C was still awaiting a response in February 2013.

Following consideration of the complaint, the Health Board was contacted and asked to provide Mr C with its substantive written response to his complaint. The Health Board agreed to do so within 14 working days.
Case reference 201204471

February 2013 – Other – Betsi Cadwaladr University Health Board
Ms S's complained about an incident that occurred in the Accident and Emergency Department at Glan Clwyd Hospital in July 2012. A response was sent to Ms S's Independent Mental Health Advocate, Ms H, by the Consultant in Emergency Medicine on 4th September 2012. Ms S then wrote to the Chief Executive, in October 2012, requesting a meeting to discuss the possibility of putting a protocol in place for future possible visits to the Accident and Emergency Department. This letter was acknowledged by Mrs W on 15th October 2012, and according to Ms S, no further correspondence had been received in relation to this request. My office subsequently contacted the Health Board, which agreed to meet with Ms S and her advocates.
Case reference 201203930

January 2013 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mrs A complained about the care and treatment given to her during a stay on a Ward of Ysbyty Gwynedd during July 2011. She also said that she was dissatisfied with the Health Board's response to her complaint about the matter and believed that the Health Board had not taken it seriously.

Having considered the documents and information provided by the Health Board, my office determined that the Health Board's investigation of Mrs A's complaint failed to comply with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and the Welsh Government's statutory guidance entitled "Putting Things Right".

The Health Board agreed to start a fresh investigation which complies with the Regulations and Guidance. Therefore, the Ombudsman was able to discontinue his investigation and settle the complaint.
Case reference 201201131

December 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Ms V complained about the treatment that her mother, Mrs D, received when she attended the Oral and Maxillo Facial Department at Ysbyty Gwynedd Hospital in June 2012. Ms V complained that the Health Board had refused to carry out further

operative procedures for excision and cautery of nerve/neuroma, which she said was the only effective treatment. Ms V also complained that the Health Board's response to her complaint failed to mention neuromas, which therefore offered an incorrect diagnosis.

Following consideration of the complaint, it was felt that it would be more appropriate for the Health Board to respond directly to the matters raised. The Health Board agreed to meet with Ms V to discuss the issues and provide some reassurance about Ms D's future treatment plan.
Case reference 201203549

November 2012 – Complaint-handling – Betsi Cadwaladr University Health Board
Ms R phoned to say that she had been waiting a number of months for a response from the Health Board. Ms R had contacted the Health Board on numerous occasions and had been assured each time that a response would be sent out that week. My office contacted the Health Board, which confirmed that a response would be sent shortly.
Case reference 201203021

November 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mr L's complaint was in relation to the treatment his late father-in-law, Mr P, received whilst a patient at Colwyn Bay Hospital. Mr L stated that he felt his complaint has been obstructed and ignored by the Concerns Team. On receiving the complaint, my office contacted the Health Board which agreed that a final response would be sent to Mr L by 21st December 2012.
Case reference 201202681

October 2012 – Other – Betsi Cadwaladr University Health Board
Mr A complained about the care given to him by the Health Board's out-of-hours service ("the OHS"). He said the OHS "failed to listen to a very ill patient who described all the symptoms of sepsis and was in desperate need of seeing a Doctor". He also said that, after he spoke to a call handler, it then took two hours for him to receive a return call from a Nurse. He said that the Nurse's call was "…very matter of fact…" and made him feel that he had "wasted their time".

Having considered the documents and information provided by the Health Board, the Health Board's investigation of Mr A's complaint failed to comply with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations") and the Welsh Government statutory guidance entitled "Putting Things Right" ("the Guidance").

The Health Board agreed voluntarily to the proposal to start a fresh investigation which complies with the Regulations and Guidance. Therefore the Ombudsman was able to discontinue his investigation and settle the complaint.
Case reference 201200428

September 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
The complainant said that he was discharged from hospital after surgery on both feet without a proper assessment of his needs for managing at home and after care. The

LHB agreed to consider a further investigation which may include a clinical review and to consider how the complainant's concerns about future management may be addressed.
Case reference 201201882

September 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mr W's complaint is split into 3 parts. Firstly, the complainant says that he has made a complaint but has not received a response. The complainant has only received a letter stating that the Health Board was sorry that the complaint has not been responded to within the timescale and was awaiting further information. The second part of the complaint relates to a request for information regarding a procedure (Colonoscopy) which was carried and has been completely ignored, with no response since 3 July 2012. Finally, the complainant complained against Bowel Cancer Screening Wales regarding a previous complaint. On receiving Mr W's complaint, my office contacted the Health Board which agreed to respond to all three aspects of the complaint by the end of this month.
Case reference 201202189

August 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mr E complained that the Health Board failed to follow through with their agreement of a meeting to discuss a complaint, which was cancelled with a few hours notice. My office contacted the Health Board to check whether the meeting could be rearranged for an earlier date than suggested. The Health Board agreed to meet at an earlier date.
Case reference 201201631

August 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board
Mr A complained about the care and treatment he received whilst an inpatient on Ward 9 at Ysbyty Glan Clwyd. Although the Health Board provided its response to Mr A's initial complaint, he remained dissatisfied with aspects of the response. Mr A therefore wrote a further letter to the Health Board, seeking clarification on a number of points. However, Mr A became concerned about the time taken by the Health Board to finalise its response and therefore complained to the Ombudsman.

During the Ombudsman's assessment of the complaint, it was noted that the Health Board had advised Mr A that it was in the process of further considering the matter. Given the circumstances, the Health Board was asked to send its response to Mr A within 10 working days and apologise for the delay Mr A had experienced in receiving this response. The Health Board agreed to do so.
Case reference 201201778

July 2012 – Other – Betsi Cadwaladr University Health Board
Ms B phoned contacted my office concerned that her son's oxygen (canister) was going to run out soon and she did not know what to do. Ms B also mentioned a letter she had received from the relevant Health Board.

My office contacted the Health Board, who advised that Ms B should contact the District Nursing Team, or call the telephone number on the canister. Alternatively, if the complainant was unable to do so, the Health Board advised she should contact the Health Board directly.

Case reference 201201218

July 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr E complained that the Health Board failed in their duty of care to his wife, Mrs E, during her time at A&E. Mr E had also been seeking to arrange a meeting with the Health in order to try and resolve his complaint face to face but had failed to arrange such a meeting.

On receiving Mr E's complaint, my office contacted the Health Board to arrange a date for the meeting. Following further enquiries, the Health Board agreed to meeting with the complainant and his wife and sent confirmation by post.

Case reference 201200701

July 2012 – Clinical treatment in hospital – Betsi Cadwaladr University Health Board

Mr J complained that after approaching the Health Board last year with concerns regarding his mother's treatment in hospital following a fall at home, the Health Board had yet to respond. Sadly, Mr J's mother died when she failed to recover from surgery.

My office contacted the Health Board which stated that a response had been drafted but held back awaiting the Coroner's verdict. The Health Board confirmed it will write to Mr J with the outcome of its investigation.

Case reference 201201149