

The Ombudsman's Casebook

Issue 24 April 2016

News

Assembly supports extension of Ombudsman's powers

PSOW Staff, Assembly Members and the Ombudsman community gathered at the Senedd last month, to mark the 10 year anniversary of the office.

Recently retired Northern Ireland Ombudsman Tom Frawley was the keynote speaker with former PSOW Peter Tyndall also giving his thoughts on his time in office.

The event was hosted by the Assembly's Presiding Officer, Rosemary Butler, with music provided by Côr Caerdydd.



Assembly supports extension of Ombudsman's powers

The Assembly Finance Committee has recently published a report which supports the strengthening of the Ombudsman's powers. The report follows a public consultation on the Draft Public Services Ombudsman (Wales) Bill and makes 18 recommendations for extending the powers.

You can find the full report and summary [here](#).

Jonathan Morgan appointed to Ombudsman Panel

Former Assembly Member Jonathan Morgan has been appointed to an advisory panel for the Public Services Ombudsman for Wales.

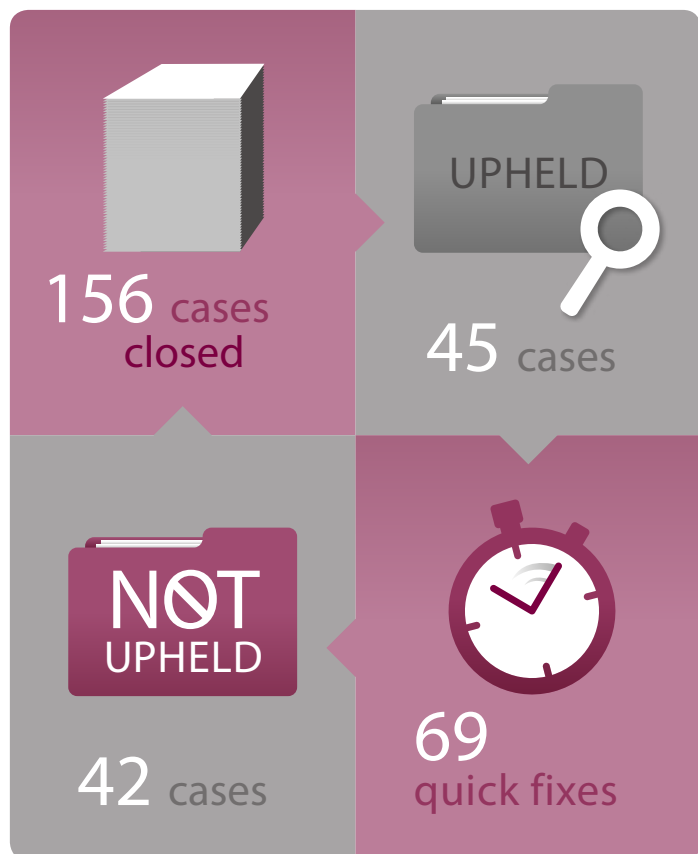
Mr Morgan, who served as an Assembly Member for 12 years, and is a former Chair of the National Assembly Public Accounts Committee, will become the newest member of both the Advisory Panel and the Audit and Risk Assurance Committee for the Ombudsman.



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Casebook in numbers



This infographic illustrates the cases closed between January and March 2016. It does not include enquiries or complaints deemed premature (where public bodies have not been given the opportunity to resolve a complaint locally) or out of jurisdiction.

Please note the quick fix category also includes voluntary settlements.

Health

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

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case reference 201501032 - Report issued in March 2016

Miss X said that her brother, Mr X, suffered from a congenital heart defect (“ACHD”) and had surgically treated kyphoscoliosos (a condition in which the spinal column is convex both backward and sideways). She complained about the insufficient regularity of investigations, notably Echocardiograms (a diagnostic test that uses ultrasound waves to make images of the heart chambers, valves and surrounding structures) (“ECHOs”), leading up to October 2011. She said that if ECHOs had been carried out every six months, treating clinicians might have detected a sub aortic membrane (a form of fixed sub aortic obstruction in which a fibrous membrane is located below the aortic valve) earlier than January 2012.

Miss X also complained that her brother could not be put on the waiting list for surgery until all tests and investigations had been completed and this took 11 months. She said that her brother was inappropriately prioritised for surgery; she said that he should have been prioritised due to his kyphoscoliosis and the effect this had on his ability to expand his lungs. Miss X said that this would not have been an issue had the investigative tests been undertaken within a reasonable time. She said that the failure to undertake ECHOs far more frequently and to undertake investigative tests within a reasonable time meant that her brother did not receive surgery in time to save his life. Mr X was 57 years old when he passed away.

The Ombudsman concluded that there was no evidence to suggest that ECHO tests should have been undertaken more frequently. This was in light of the fact that the degree of obstruction caused by Mr X’s sub aortic membrane (the narrowing of the left ventricle of the heart just below the aortic valve through which blood must pass) would have been unlikely to have been detected earlier than January 2012, which prompted the need for surgery. Given that there was no significant deterioration in Mr X’s condition between October 2011 and December 2012, the Ombudsman found that the Health Board did not prioritise Mr X for surgery inappropriately. The Ombudsman upheld the complaint about the clinical advice given to Mr X during his wait for surgery. There was no evidence that Mr X was made aware of worrying symptoms. The Ombudsman upheld the complaint regarding Mr X’s wait for treatment. Treatment should have been supplied within 26 weeks, but Mr X was not due to receive treatment until 50 weeks had elapsed. Had Mr X received surgery more promptly, on the balance of probabilities, his death would have been avoided. The Ombudsman therefore took the view that Mr X’s death was avoidable.

The Ombudsman recommended that:

- a) the Health Board’s Chief Executive personally apologise to Miss X for the failings identified in this report, most notably, Mr X’s avoidable death

b) the Health Board conclude its “mirror” process to that conducted under the “Putting Things Right” (“PTR”) in order to assess the level of compensation that it should offer to Mrs X in respect of the avoidable death of Mr X. The Health Board confirmed that the file has already been shared with its legal department for this purpose and, with that in mind, it should conclude this process within three months of the date of issue of the report.

c) the Health Board ensure that the British Heart Foundation leaflet entitled ‘Heart Valve Disease’ is given to every relevant patient at clinic and that the checklist is completed to reflect this, and that appropriate advice has been given. The Health Board should also ensure that all Cardiology clinicians are aware of this requirement.

The Health Board agreed to implement the recommendations.

OTHER REPORTS - UPHELD

Hywel Dda University Health Board – Clinical treatment in hospital

Case reference 201408260 – Report issued in January 2016

Mrs Y complained about Hywel Dda University Health Board's ("the Health Board") care and treatment provided to her father, Mr X, for his throat cancer. Substantively, the complaint concerned the delay in the identification and diagnosis of Mr X's throat cancer which Mrs Y said delayed the start of his treatment and ultimately impacted on his treatment options and his future prognosis. Mrs Y complained that the Health Board did not adequately communicate and support Mr X, his wife and his family during the management of this condition and said the Health Board's complaint response failed to address Mr X's specific concerns.

The investigation found that the Health Board had failed to identify and triage Mr X's GP and Private Consultant's referrals as Urgent Suspected Cancer ("USC") in line with the criteria set out in NICE guidelines. As a result, the Health Board failed to meet the Welsh Government's target dates for the start of Mr X's treatment in accordance with the National Cancer Standards.

The Ombudsman concluded there were unacceptable delays by the Health Board which amounted to service failure in Mr X's care. Whilst these delays were unlikely to have affected Mr X's available treatment options and overall prognosis, there remained an element of doubt and to this extent, the Ombudsman upheld Mrs Y's complaint. Mrs Y's complaint about the Health Board's complaints handling and its inadequate response was also upheld. Mrs Y's complaint about the Health Board's lack of communication and support was partly upheld, although it was found that this was not inadequate following Mr X's diagnosis. The Health Board had recognised certain shortcomings in this regard and had apologised to Mrs Y.

The Ombudsman recommended that the Health Board should:

- a) apologise to Mrs Y for the shortcomings identified in the report
- b) provide financial redress and make a payment to Mrs Y of £250 for her time and trouble in pursuing the complaint and the identified shortcoming in the complaints response
- c) provide financial redress and make a payment to Mr X of £1000 in recognition of the distress and uncertainties caused by the shortcomings identified in the report
- d) carry out an audit of its referrals to determine whether they have been properly identified and triaged as USC in line with NICE guidelines for suspected cancer. Provide evidence of this audit to the Ombudsman office
- e) encourage clinicians to follow up a patient's investigation results and to communicate those results with patients and their GPs, in a timely manner.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital **Case reference 201405336 – Report issued in January 2016**

Mrs A and Ms B complained about the care and treatment provided to their mother, Mrs C, during her admissions to the Princess of Wales Hospital in January 2013. The complaints related to the management of Mrs C's chronic kidney disease (CKD), the decision to discharge her from hospital and the alleged delay in transferring her to the Intensive Therapy Unit (ITU). Sadly, Mrs C died shortly after her transfer to ITU.

Having obtained professional advice on the clinical issues from a Renal Consultant and Consultant Cardiologist, the Ombudsman upheld the complaint. The evidence confirmed that there were shortcomings in the care provided to Mrs C which reduced the likelihood of a better outcome. In particular, the investigation concluded that more priority ought to have been given to her CKD as the possible cause of her symptoms and the need for dialysis. Furthermore, the renal advice provided was inadequate and there was a lack of consultant to consultant discussions. The Ombudsman also found that Mrs C's discharge was inappropriate, which had been accepted by Abertawe Bro Morgannwg Health Board ("the Health Board"), and that there were clinical indications for an earlier transfer to ITU.

The Ombudsman recommended that the Health Board should:

- a) provide the family with an apology for the failings identified
- b) review Mrs C's case to consider and address the failings identified including the decision not to commence earlier dialysis, the deficiencies in interdepartmental communication and staffing issues on the ward
- c) remind nursing staff of the importance of good record keeping
- d) reflect on its complaints responses
- e) consider the report as part of the involved consultants' next appraisals.

The Ombudsman was minded to recommend a redress payment of £2,000. However, the family did not wish to receive any financial redress.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital **Case reference 201501221 - Report issued in January 2016**

Miss K complained about an inappropriate psychiatric referral shortly after she gave birth and was re-admitted to the maternity ward with high blood pressure. She was also dissatisfied with record keeping on her medical records and Betsi Cadwaladr University Health Board's (the Health Board) handling of her complaint.

The Ombudsman, having sought clinical advice, concluded that the medical records did not provide sufficient evidence to have warranted a psychiatric review albeit it may have been done with the best of intentions. Additionally, there was no evidence that Miss K had been informed or consented to the referral. The Ombudsman was critical that the referral had been made by a clinician who had not spoken to or reviewed Miss K. There was also evidence of inadequate and poor medical and nursing record keeping and information that the clinician had sought to rely on in her referral was not evidenced in the medical records. The clinical aspect of Miss K's complaint as well as the administrative failings caused by

poor record keeping was upheld.

The Ombudsman recommended that the Health Board:

- a) apologise to Miss K for the failings
- b) make a payment to her of £750 for the distress caused which extended to shortcomings in the Health Board's handling of Miss K's complaint.

Finally, recommendations were also made concerning record keeping and reflective learning by clinicians.

Hywel Dda University Health Board – Clinical treatment in hospital

Case reference 201501606 - Report issued in January 2016

Mr A complained that Mrs A had not been adequately hydrated while admitted to Bronglais Hospital. Mr A complained that Mrs A had fallen, nothing had been done to prevent this and no action had been taken to prevent this from reoccurring. Mr A also complained that the Incident Investigation Form ("the IIF"), completed by nursing staff following the fall, was inadequate and did not properly reflect the adverse clinical outcome of the fall.

The Ombudsman concluded that, overall, Mrs A's hydration needs were met and the inadequate completion of the IIF did not result in any injustice. He did not uphold these complaints. The Ombudsman concluded that falls risk assessments had not been carried out and that, although these may not have prevented a fall, this was a failing which left Mr A uncertain about whether the fall might have been avoided. The Ombudsman upheld this part of the complaint. He recommended that Hywel Dda University Health Board ("the Health Board") should:

- a) apologise to Mr A for the failure to assess the risk of Mrs A falling
- b) remind relevant staff of the importance of falls risk assessments.

The Health Board agreed to comply with these recommendations.

GP Surgery in the Betsi Cadwaladr University Health Board area – Clinical treatment outside of hospital

Case reference 201408823 – Report issued in January 2016

Mrs D complained about the care and treatment that her elderly mother, Mrs M, received from a GP who visited her at home following a fall in which she injured her wrist. Mrs D complained that in spite of her mother's symptoms of severe pain, swelling, bruising and restricted movement, the GP failed to investigate the possibility that her wrist was fractured and failed to advise her to attend her local Accident and Emergency Department for an X-ray. Mrs D described how an X-ray, taken some weeks later, revealed that her mother had sustained a serious fracture which, by then, had healed with a degree of malunion. This resulted in Mrs M suffering a loss of wrist function which, among other things,

impaired her ability to support herself with her zimmer frame.

Mrs D also complained that the Surgery failed to ensure that a follow-up visit was conducted by another GP or the District Nursing Service (DNS) and, finally, that she encountered considerable difficulty and frustration in her attempts to meet with the Surgery's Practice Manager to discuss her complaint.

The Ombudsman upheld Mrs D's complaints and recommended that:

a) the Head of Practice provides Mrs D with a fulsome written apology for the failure of the Surgery to refer Mrs M for an X-ray and for the confusion surrounding Mrs D's attempts to meet with the Practice Manager and the inconvenience this gave rise to

b) the Surgery makes a payment to Mrs M in the sum of £500 and a payment to Mrs D in the sum of £250

c) the Surgery conducts a review of its system of internal communications between GPs and the DNS and considers how to ensure that GPs receive confirmation that visits have been carried out by district nurses

d) the Surgery undertakes to provide training to its non-clinical staff in regard to advising patients on how to submit complaints and concerns to the Surgery in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside of hospital

Case reference 201409514 – Report issued in January 2016

Mr and Mrs R complained to the Ombudsman about a failure by Abertawe Bro Morgannwg University Health Board ("the Health Board") to diagnose and manage their son's (referred to as "D") condition which presented symptoms which could be indicative of Myalgic Encephalomyelitis (ME), Chronic Fatigue Syndrome (CFS) or Chronic Pain Syndrome (CPS). The Ombudsman, based on his specialist clinical advice, found that the Health Board's acceptance of a diagnosis of Chronic Pain Syndrome was reasonable given the overlapping nature of the three conditions and that the approach the Health Board took to treating the symptoms D was experiencing was reasonable, regardless of any definitive diagnosis.

However, the Ombudsman did find that the Health Board had not provided D with appropriate follow up and review of his care plan and that a breakdown in the relationship between the family and the Health Board had occurred.

The Ombudsman upheld the complaint to this limited extent. He recommended that:

a) the Health Board apologise to the family and arrange for a care management plan to be prepared for D

b) the Health Board arrange for D to receive regular follow-ups from a paediatric clinician with expertise

in chronic pain/fatigue, and

c) that there should be close liaison to ensure that D's care is co-ordinated.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital **Case reference 201501946 – Report issued in January 2016**

Mrs X complained that a note from a radiologist querying her husband's distended bladder (inability to fully empty the bladder) was not passed on to him or his GP by the Consultant Dermatologist ("the Consultant"). As a result, Mr X was unaware of his urological issues until February 2014 and he could no longer pass urine.

The investigation found that, whilst it may have been ideal for the Consultant to have passed on the note from the radiologist, there was no evidence to suggest that this amounted to a service failure. The Consultant appropriately investigated Mr X's dermatological symptoms and referred him to a Consultant Neurologist for investigation of abnormalities in the lumbar spine. The Consultant was also aware of a letter from the Consultant Urologist sent around that time confirming that Mr X's bladder was "entirely normal".

The Ombudsman did not uphold the clinical complaint. The Ombudsman did however consider that Betsi Cadwaladr University Health Board's ("the Health Board") response to the complaint was unreasonably delayed as it took almost thirteen months.

The Ombudsman made the following recommendations:

- a) that the Health Board should apologise to Mr X for the delay in handling his complaint
- b) that the Health Board should make a payment of £250 to Mr X in respect of the delay.

The Health Board agreed to implement the recommendations.

Aneurin Bevan University Health Board - Clinical treatment outside hospital **Case Reference 201405404 – Report issued in February 2016**

Mr X complained about the care and treatment that his mother, Mrs X, received while she was resident at a Care Home with Nursing. Mr X was of the view that his mother's needs had not been met and that she had not received adequate care. Mr X said that when Mrs X was eventually admitted to hospital, she was in a very poor state and sadly died a few days later.

Mr X was also concerned about the Protection of Vulnerable Adults ("POVA") investigations which involved Aneurin Bevan University Health Board ("the Health Board") and did not find neglect. Mr X also complained about the Health Board's complaint response.

The concerns raised by Mr X involved a number of bodies, including the Care Home operated by Plasgeller Care Home Ltd, Blaenau Gwent County Borough Council and a GP Practice in the area. This investigation focused particularly on the Health Board in respect of its role as the commissioner of NHS Funded Nursing Care and later Continuing NHS Health Care ("CHC"). The Health Board also provided community mental health services to Mrs X at the Care Home.

The Ombudsman, taking account of clinical advice, was satisfied with a number of the Health Board's actions; however, he identified two shortcomings. Firstly, he found that the CHC assessment had not been carried out with sufficient urgency and there was a delay in agreeing the arrangements/funding for one to one supervision for Mrs X.

Secondly, the Ombudsman found that Mrs X did not receive a change in medication, as planned by the mental health service in a timely manner. The Ombudsman could not be wholly clear as to the impact of these shortcomings, but was of the view that the uncertainty resulted in some injustice to Mrs X and her family. The Ombudsman therefore partially upheld Mr X's complaint.

The Ombudsman also partially upheld the complaint about the Health Board's complaint response. It did not identify the shortcomings and was not jointly addressed with the Council's Social Services as had been intended. There was, however, nothing to suggest that the Health Board had not adequately considered the POVA concerns which were raised.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr X for the identified shortcomings
- b) review its arrangements for the provision of urgent one to one support pending CHC considerations
- c) ensure that communication between the mental health services and the GP is clear and formalised.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Reference 201500485 - Report issued in February 2016

Mr A complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to diagnose and treat his daughter, Ms B, for Guillain-Barré syndrome ("GBS"). He also complained that Ms B received inadequate nursing care during her stay in hospital, and about the delay in the Health Board's handling of his complaint. Ms B was admitted to hospital on 19 March 2014, but, sadly, died on 26 March.

The Ombudsman found that the seriousness of Ms B's condition was not appreciated, and the deterioration in her condition not recognised or acted upon with a sufficient degree of urgency. The Health Board did not diagnose Ms B with GBS and did not provide appropriate treatment for her; however, the Ombudsman could not say if she would have survived but for the failings he identified.

The nursing care had been generally of a good standard, and he was not critical of the Health Board's delay in handling Mr A's complaint. The Ombudsman partly upheld the complaint. He recommended that the Health Board:

- a) apologise to Mr A for the failings
- b) pay Mr A the sum of £5000 in recognition of the distress caused, and
- c) share the complaint with medical staff so that lessons might be learned for the future.

**Cardiff and Vale University Health Board, Cardiff Council, Hallmark Care Home Ltd and a GP in the Health Board area - Health - Continuing care
Case References 201402286, 201405648, 201405816, 201500032 & 201500813 – Report issued in February 2016**

Mrs X has complained about the care and treatment her mother, Mrs Y, received from Cardiff and Vale University Health Board (“the Health Board”), Cardiff Council (“the Council”), Hallmark Care Home Ltd (“the Care Provider”) and the Surgery between 7 June and 17 November 2013.

The Ombudsman found that the care and treatment provided by the Health Board and the Care Provider was unreasonable. There had been a failure to assess Mrs Y, create appropriate person centred care plans, monitor her weight and nutrition and maintain her hygiene. This treatment was undignified and placed Mrs Y’s safety at risk.

The Ombudsman found that the Council failed to carry out appropriate assessments and made assumptions regarding Mrs Y’s diagnosis which caused added distress to the family.

The Ombudsman found that the Surgery failed to create adequate records during the original examination, which impacted on the subsequent visits made by GP’s from the Surgery.

Finally, the Ombudsman found that the bodies had failed to adequately communicate with Mrs Y and her family which resulted in them feeling frustrated and distressed given their knowledge of Mrs Y’s condition and their concerns about her treatment and subsequent deterioration.

The Ombudsman recommended that:

- a) all four bodies apologise to Mrs X
- b) the Health Board and Care Provider pay Mrs X the sums of £1,000 and £1,500 respectively in recognition of the distress experienced and the time and trouble in bringing her complaint to the Ombudsman.

He also recommended that the Health Board:

- a) remind staff about the importance of clear communication and accurate record keeping. It should also ask the Dietician to remind staff of the benefits of nutrition on wound healing
- b) review its training plan to include treating patients with dignity, record keeping, assessments and care planning
- c) discuss the outcome of the report with the relevant staff in supervision sessions
- d) provide Mrs Y with an updated copy of the action plan created on 29 July 2014 and keep her updated on any ongoing work
- e) conduct an audit of the discharge process.

He recommended that the Council:

- a) remind staff about the need for accuracy when completing assessments
- b) provide Mrs X with an updated copy of the action plan created on 2 December 2014 and keep her updated on any ongoing work.

He recommended that the Care Provider:

- a) remind staff about the need for accurate record keeping, assessments and care planning, as well as the need to monitor hydration and nutrition
- b) review its training plan to include treating patients with dignity, POVA, record keeping, risk assessment and care planning
- c) discuss the outcome of the report with the relevant staff in supervision sessions
- d) conduct an audit of its records
- e) review the process for incidents and injuries to residents.

Finally, it was recommended that the Surgery write to Mrs X outlining the action taken as a result of her complaint.

A GP in the area of Powys Teaching Health Board - Clinical treatment outside hospital Case Reference 201502300 – Report issued in February 2016

Mr Y complained about the care and treatment he received from his GP Practice on 27 September 2013. Mr Y complained that despite needing an emergency appointment, there was a failure to see him in a timely manner. He also complained that it was unreasonable for the GP to ask for an ambulance response time of 30 minutes rather than eight minutes and that he should have been referred to the closer Nevill Hall Hospital for treatment rather than taken to the Royal Gwent Hospital.

The Ombudsman found that the delay in acknowledging and assessing Mr Y was unreasonable. He also found that the decision to request a 30 minute response time had been based on guidance provided by the Welsh Ambulance Service Trust, and the decision to refer Mr Y to the Royal Gwent Hospital had been made by the Health Board.

The Ombudsman recommended that the Practice:

- a) apologise to Mr Y, and
- b) write to Mr Y outlining what action it intends to take or has taken as a result of his complaint and the outcome of those actions.

Abertawe Bro Morgannwg University Health Board - Appointments/admissions/discharge and transfer procedures

Case Reference 201500250 – Report issued in February 2016

Mrs A complained to the Ombudsman that she had been waiting an excessive period of time for an operation to remove her gall bladder. Ultimately, she waited 48 weeks for the procedure from the point she was referred by her GP. During this period she attended A&E four times, gave up her work and was on high doses of pain killers.

The Ombudsman found that Abertawe Bro Morgannwg University Health Board (“the Health Board”) had taken too long to perform the procedure and did not manage Mrs A’s treatment in keeping with NICE guidelines. He found this to be a failure to provide Mrs A with a reasonable service. He upheld the complaint and recommended that the Health Board:

- a) apologise to Mrs A, and
- b) provide her with redress of £500 for the injustice she experienced in relation to her ongoing pain and distress.

He also recognised the Health Board’s on-going difficulties in achieving Welsh Government targets for providing treatment to patients. He therefore recommended that if the Health Board was unable to demonstrate a significant improvement in patient treatment times within four months it should explain its plans for addressing the situation to the Ombudsman, Welsh Government and Healthcare Inspectorate Wales.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Reference 201500659 - Report issued in February 2016

Mrs R complained to the Ombudsman about the treatment her mother (Mrs P) received while a patient at Wrexham Maelor Hospital diagnosed with liver and cardiac failure. She was concerned that her mother had not been treated in the cardiac unit for her cardiac difficulties. She was also aggrieved that her mother was considered by her doctors to be terminally ill and was subject to a DNAR order. Mrs R considered that this resulted in her mother being discharged to a palliative care facility inappropriately. Furthermore she did not receive appropriate follow-up care even though her mother’s condition had improved. Mrs R also said that staff had amended her NEWS score thereby delaying her transfer to a more intensive care setting.

The Ombudsman found that Mrs P’s care setting had been appropriate. He also considered that, on balance, it was reasonable for Mrs P to have been considered terminally ill and that the decision to issue a DNAR was appropriate. He was however critical of the failure to review Mrs P’s care and management plan after her condition had improved somewhat and upheld this aspect of the complaint. He also found that the Health Board had failed to provide any evidence to indicate that they had investigated the recording of Mrs P’s NEWS score at the time Mrs R had complained. Accordingly, he also upheld this aspect of the complaint and recommended that Betsi Cadwaladr Health Board (“the Health Board”):

- a) apologise to Mrs P

- b) pay Mrs P £200 redress
- c) give the clinicians in Mrs P's care an opportunity to reflect on the case, and
- d) investigate the concerns raised about the altering of Mrs P's NEWS.

Cardiff and Vale University LHB - Medical records/standards of record-keeping

Case Reference 201503019 – Report issued in February 2016

Miss B complained that she was not given her rights when she was detained under Section 2 of the Mental Health Act and that her patient experience was poor because Cardiff and Vale University LHB ("the Health Board") did not provide her with important information. She also said patient safety was compromised because the Health Board did not accurately record when she returned from leave.

The Ombudsman partially upheld the complaint as information was not accurately recorded. However, there was no evidence to suggest that patient safety was compromised. He recommended that the Health Board:

- a) write to Miss B to apologise for not accurately completing the records, and
- b) remind staff of their responsibility to provide patients with their rights and ensure that they fully and accurately record that they have done so.

Aneurin Bevan University Health Board – Clinical treatment outside hospital

Case reference 201500179 - Report issued in February 2016

Ms C was dissatisfied with the management and care that she received from Aneurin Bevan University Health Board's ("the Health Board") Mental Health and Learning Disabilities Home Treatment Team ("HTT"). In particular, she felt that she had been forced to take medication. She was also unhappy that actions on the part of the HTT had led to a breach of her confidentiality. Finally, Ms C raised concerns about the Health Board's handling of her complaint.

The Ombudsman's investigation identified that the informed consent process had not been fully followed when it came to Ms C's medication. For example, she was not offered any alternative anti-psychotic medication and the risks and benefits of the drug were not explained at the point when it was prescribed. The Ombudsman also concluded that Ms C had been coerced to take medication under threat of a mental health assessment or being detained in a psychiatric hospital.

Administratively, the Ombudsman found evidence of poor record-keeping which had also been a feature in the breach of Ms C's confidentiality. Finally, there were shortcomings in the Health Board's handling of Ms C's complaint.

The Ombudsman's recommendations included:

- a) an apology from the Chief Executive to Ms C for the shortcomings in both her care and complaint handling

b) a payment to Ms C of £700 in recognition of the failings, and

c) the HTT to review its processes and procedures and put in place measures to address the clinical and administrative failings identified.

A GP Practice in the area of Cwm Taf University Health Board – Clinical treatment outside hospital

Case reference 201409493 - Report issued in February 2016

Mr A complained that when his wife, Mrs A, attended the Practice in November 2014, a GP misdiagnosed her condition as a chest infection. Early the following morning, Mrs A tragically passed away. The cause of death was coronary thrombosis (a blood clot in an artery). Mr A considered that had the GP made a correct diagnosis, Mrs A could have been referred to hospital and her death could have been prevented.

The Ombudsman found that the assessment of Mrs A's condition fell short of what would reasonably be expected from a GP. Even accepting that the findings recorded by the GP were consistent with the diagnosis of chest infection, in taking into account NICE guidance on chest infections, the clinical advice of the Ombudsman's professional advisers and the abnormal findings recorded by the GP (most significantly the oxygen saturation level of 87%), the Ombudsman found that Mrs A's clinical presentation should have led to a hospital referral.

The Ombudsman upheld Mr A's complaint and made a range of recommendations. These included:

a) an apology and redress of £1,500 to Mr A for the distress caused by the identified failings

b) the GP to declare the complaint and discuss it at his next appraisal

c) a Practice meeting to be held to discuss the findings and consider how it can improve future management and care of its patients, and

d) the GP to take action to ensure compliance with GMC guidance.

The Practice agreed to implement the recommendations.

Abertawe Bro Morgannwg University Health Board – Patient list issues

Case reference 201502095 - Report issued in February 2016

Ms M complained about Abertawe Bro Morgannwg University Health Board's ("the Health Board") delay in carrying out anti-reflux surgery. The Ombudsman concluded that the failure to offer Ms M treatment within the timescale allowed by the waiting time rules was on the face of it a service failure. However, he noted that in the intervening period Ms M's medication for the condition which was at a low dosage remained unchanged. Furthermore, there was no indication from the GP records that Ms M's condition had worsened. To that extent there was no evidence that the delays had caused Ms M personal injustice.

The Ombudsman therefore did not uphold this aspect of her complaint.

The Ombudsman identified communication failings as the Health Board did not write to Ms M to inform her that she had been placed on the waiting list as it should have done. The Ombudsman upheld this aspect of Ms M's complaint, and recommended that the Health Board:

- a) apologise to Ms M
- b) pay Mrs M a redress payment of £50 in recognition of the time and trouble in pursuing the Health Board for a follow up appointment.

Welsh Ambulance Services NHS Trust ("WAST") – Ambulance Services Case reference 201501167 - Report issued in March 2016

Dr M complained about the WAST's management and care of her late husband. Amongst the concerns she raised was that there was a delay in the ambulance arriving. In addition, she said the paramedic had failed to make a confirmed diagnosis of a heart attack in relation to her husband and did not give him any pain relief. Finally, Dr M was dissatisfied with WAST's handling of her complaint.

The Ombudsman's investigation concluded that the care and treatment provided to Dr M's husband was appropriate, reasonable and provided in a timely manner in accordance with national and local guidance. He did not uphold this aspect of Dr M's complaint.

The Ombudsman did identify shortcomings in the WAST's investigation and complaint responses to Dr M which affected her confidence in the information provided and therefore added to her distress. The Ombudsman upheld this aspect of her complaint and recommended that WAST:

- a) apologise to Dr M, and
- b) pay Dr M a sum of £250 for the time and trouble caused to her in having to pursue her complaint.

Abertawe Bro Morgannwg University Health Board and Velindre NHS Trust – clinical treatment in hospital

Case reference 201501763 & 201501764 - Report issued in March 2016

Mrs A complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to diagnose her husband's secondary cancer despite him undergoing many investigations. She said there was also a delay in him being seen by the Urology Department. Mrs A said that despite her husband's deteriorating health, no measures were put in place for him to have palliative care. This led to poor pain control. In addition, Mrs A complained that the Trust's Consultant Oncologist failed to recognise her husband's symptoms and examine him during a consultation. Mrs A said that she had described her husband's symptoms to the Consultant Oncologist and that these included loss of appetite, weight loss and a hoarse voice.

The Ombudsman's investigation identified shortcomings in the care provided to Mrs A's husband by the Health Board and the Trust and upheld Mrs A's complaint.

The Ombudsman recommended that:

- a) both the Health Board and the Trust apologise to Mrs A for the shortcomings found
- b) the Health Board pay Mrs A £350 for the difficulties her husband encountered around an endoscopy scan and for the distress caused by the failure to make a referral for nutritional input.

Cardiff and Vale University Health Board – clinical treatment in hospital Case reference 201500157 - Report issued in March 2016

Dr A complained about the standard of care provided to his mother-in-law (Mrs D) at the University Hospital of Wales between November and December 2013 after she was admitted with right knee pain following a fall some four weeks previously. In particular, Dr A was concerned that there was a delay in obtaining an orthopaedic assessment and accurate diagnosis, that there was a refusal to accept an orthopaedic referral and that there was a failure to recognise that Mrs D had been over-sedated and that Cardiff and Vale University Health Board (“the Health Board”) failed to address this issue in its response to his complaint.

The Ombudsman found that any apparent delay in obtaining an orthopaedic assessment or accurate diagnosis did not appear to have any adverse effect on Mrs D’s care and treatment given that the treatment plan after diagnosis remained unchanged to that on admission. He also concluded that there was no refusal to accept an orthopaedic referral. In terms of Dr A’s concern about over-sedation, this was recognised and quickly rectified and there was no adverse outcome to Mrs D as a result of this event. These complaints were not therefore upheld.

The Ombudsman upheld Dr A’s complaint that the Health Board failed to address the issue of over-sedation in its response. He recommended that the Health Board should apologise to Dr A for this failure.

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

Case reference 201501426 - Report issued in March 2016

Mrs X complained about the inappropriate hospital discharge of her mother, Mrs Y, on two separate occasions (February and April 2015) from Ysbyty Ystrad Fawr. Mrs X said that her mother had not received adequate rehabilitation. Mrs X referred to concerns about the management of her mother’s continence and about the use and safety of ‘chair raisers’. Mrs X also complained about Aneurin Bevan University Health Board’s (“the Health Board”) response to her complaint.

Taking account of advice from a number of his Clinical Advisers, the Ombudsman found that there was no evidence to support a view that Mrs Y should not have been discharged from hospital on either occasion. He noted that a key issue was that Mrs Y was judged to have mental capacity and the ability to make her own decisions about where she wanted to live. He also noted that Mrs X’s reservations were properly taken into consideration.

The Ombudsman found that there was no evidence of any significant service failure. He noted that many elements of care were well delivered. Nevertheless, he did identify shortcomings in record keeping which meant it was impossible to confirm that all aspects of care were satisfactory. He was of the view that this

did result in some small level of injustice. To the limited extent of this shortcoming, the Ombudsman partly upheld the complaint.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs Y, and
- b) carry out an audit of record keeping.

He did not uphold the complaint about the Health Board's complaint response.

Betsi Cadwaladr University Health Board – clinical treatment in hospital

Case reference 201409310 - Report issued in March 2016

Mrs D complained to the Ombudsman about the care and treatment that her late mother-in-law, Mrs M, received from her GP and from hospital clinicians prior to and following her admission, in 2012, to Ysbyty Glan Clwyd ("YGC") with a cancerous, ovarian mass. Mrs D complained about:

- a) failings in the care and treatment provided to Mrs M by her GP during a home visit prior to her admission to YGC
- b) failures of communication between hospital clinicians and the family in respect of Mrs M's care plan and confusion surrounding the date on which her surgery was scheduled
- c) failings in the post-operative nursing care that Mrs M received at YGC and subsequently at Holywell Community Hospital that led to her developing a pressure ulcer
- d) excessive delay and other communication failings in Betsi Cadwaladr University Health Board's ("the Health Board") handling of her complaints about these matters.

The Ombudsman upheld Mrs D's complaints about communication and complaint-handling failings but did not uphold Mrs D's complaints about poor clinical care. The Ombudsman recommended that the Health Board:

- a) provide Mrs D with a fulsome apology
- b) pay Mrs D £500 for the time, trouble and inconvenience that was entailed in her pursuing her complaint about these matters, and
- c) improve communication processes surrounding the sharing of decisions made at multi-disciplinary team meetings and in interactions between the Health Board's Concerns Team and complainants.

Cardiff and Vale University LHB – clinical treatment in hospital

Case reference 201503301 - Report issued in March 2016

Mrs X complained about the care and treatment her husband, Mr X, received during his admission to hospital. Specifically, Mrs X complained about the failure to investigate Mr X's increased levels of creatine

kinase. Mrs X also complained that Mr X was administered intravenous antibiotics despite normal blood tests. Finally, Mrs X complained that Mr X's diagnosis was amended and he was discharged from hospital despite the evidence on his chest X-ray, and that there was no explanation why his diagnosis and treatment plan changed.

The Ombudsman found that in the absence of a heart related illness, there was no reason to continue investigating the creatine kinase levels. He also found that given the initial diagnosis of possible pneumonia, it was reasonable to start a course of antibiotics. Finally the Ombudsman found that given the results of the clinical investigations, and Mr X's examination it was reasonable for the diagnosis to change. However there was a failure to discuss the diagnosis, prognosis, treatment plan or any associated changes with Mr and Mrs X.

The Ombudsman recommended that Cardiff and Vale University LHB:

- a) apologise to Mr and Mrs X
- b) pay them £250 in recognition of the time and trouble in bringing their complaint to this office
- c) remind the relevant officers of the need to communicate with a patient and their family and record conversations, and
- d) ask the relevant officers during their next supervision sessions to reflect on the findings of the report and the effect of poor communication on patients and family members.

Cardiff and Vale University LHB – clinical treatment in hospital

Case reference 201503406 - Report issued in March 2016

Mrs X complained that, despite being referred to hospital by her GP as an emergency admission, no investigations or examinations were undertaken. Mrs X also complained that there was a failure to provide an explanation of her condition and pain relief options, that there was a failure to administer pain relief and finally, that the clinicians failed to take responsibility for her because she was under the care of a Consultant.

The investigation found that Mrs X had been admitted to hospital because of increased pain, and given Mrs X's medical history and ongoing treatment plan there was no indication for the need of additional investigations at that time. However, it was recognised that the doctor responsible for her care failed to discuss Mrs X's plan of care with her.

The investigation also found that in view of Mrs X's increased pain and her poor tolerance of analgesics, it was reasonable to wait until she had been seen by the Pain Management Team before prescribing medication. Finally, the investigation found no evidence of Mrs X being disregarded by the clinicians because she was already under the care of a Consultant.

It was recommended that Cardiff and Vale University LHB:

- a) apologise to Mrs X

b) remind the doctor responsible for Mrs X's care of the importance of meaningful discussions with patients about treatment plans and that he reflect on Mrs X's case during his next supervision session.

Cwm Taf University Health Board – Clinical treatment in hospital

Case reference 201500113 - Report issued in March 2016

Mr B complained to the Ombudsman about the care his son, Mr M, received from Cwm Taf University Health Board ("the Health Board"). Mr B suffered from a degenerative condition which meant that he had additional nursing and care needs. Mr B complained there was a lack of communication with him about his son's care and treatment whilst in hospital, that hospital staff did not address his needs appropriately and he was also concerned about discharge arrangements. Mr B was also concerned about the level and intensity of support he and his son received from the district nursing service when Mr M was discharged home. Mr B was also concerned about the end of life care provided to his son.

The Ombudsman found that communication with Mr B had been inadequate and that there were shortcomings in the engagement with Mr M. He upheld that aspect of the complaint. Whilst the discharge arrangements were poor on one occasion, there was no injustice to Mr M. The Ombudsman was unable to find evidence of a failure to provide Mr B with an adequate nursing care. He also found that the end of life care provided to Mr M had been adequate. Accordingly, these aspects of the complaint were not upheld. Finally, the Ombudsman found that the District Nursing care provided to Mr M was inadequate.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr M and his family for the shortcomings identified
- b) remind nursing staff of the need for person centred care
- c) provide training and support to district nursing staff , and
- d) give Mr B the opportunity to share his experience with the Health Board in an appropriate forum.

A GP Practice in the Betsi Cadwaladr University Health Board area – Clinical treatment outside of hospital

Case reference 201502614 - Report issued in March 2016

Mrs X complained about the care and treatment provided to her late father, Mr Y, by the Practice. In particular, Mrs X complained about the discontinuation of her father's prostate cancer medication, Zoladex, between June 2010 and November 2011, and the care and treatment provided by the Practice in respect of his prostate cancer.

The investigation found it was highly unlikely that, had Mr Y been given the medication for the period in question, it would have increased his life expectancy. This was due to the fact that Zoladex is given to control the cancer for as long as possible, but it is not a cure. Over time, many prostate cancers become resistant to Zoladex and begin to grow and there was evidence of this in Mr Y's case. This aspect of the complaint was not upheld.

The investigation did however find that the Practice failed to monitor Mr Y's prostate cancer effectively. Had they done so, it was likely that the cancer would have been detected earlier and a referral to a urologist may have resulted in different therapies being offered. The Ombudsman considered this a failing and upheld this aspect of the complaint.

He recommended that the Practice:

- a) apologise to Mrs X for failing to appropriately manage Mr Y's cancer treatment
- b) pay Mrs X the sum of £2,500 to reflect that failing

The Practice agreed to implement the recommendations.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital **Case reference 201501341 – Report issued in March 2016**

Mrs D complained on behalf of her late husband, Mr D, about the care and treatment he received at Glan Clwyd Hospital ("the Hospital") between 24 December 2014 and 30 January 2015. The Ombudsman concluded that there was no evidence to suggest that Mr D was in pain and that his pain was adequately managed by Betsi Cadwaladr University Health Board ("the Health Board"). He was also satisfied that the management of Mr D's dementia medication was reasonable and that he was not adversely affected by missed medication. However, the Ombudsman found failings in Mr D's discharge from the Hospital on 31 December 2014. He also found that Mrs D should have been informed of her husband's biopsy results.

The Ombudsman recommended that the Health Board:

- a) issue a letter of apology to Mrs D for the failure to inform her of the results of her husband's biopsy and the poor management of Mr D's discharge from the Hospital
- b) remind staff of the importance of comprehensive and systemic record keeping, and
- c) ensure that all members involved in Mr D's discharge receive appropriate training on the relevant policies and procedures in relation to appropriate discharge planning.

Betsi Cadwaladr University Health Board - Other **Case reference 201501717 - Report issued in March 2016**

Miss K complained about the procedure followed by Betsi Cadwaladr University Health Board ("the Health Board") and Shrewsbury and Telford NHS Trust ("the Trust"), following her request for fertility treatment. In particular, Miss K complained that she was provided with incorrect advice at her initial consultation regarding her eligibility for NHS funded in vitro fertilisation ("IVF") treatment using donor sperm.

The investigation found that Miss K was not eligible for NHS funded IVF treatment when she attended her first consultation, however; she was incorrectly referred to the Trust for treatment. The investigation identified missed opportunities to inform Miss K that an error had been made. The Ombudsman

recommended that the Health Board:

- a) issue Miss K with a letter of apology to reflect the failure to correctly advise her that she was not eligible for fertility treatment under the NHS
- b) provide Miss K with a payment of £500 in recognition of the stress and delay caused by the incorrect advice provided to Miss K, and subsequent failures in notifying her that an error had been made, and
- c) ensure that all members of staff involved in this complaint have received appropriate training on the relevant policies which determine eligibility for NHS funded fertility treatment.

Aneurin Bevan University Health Board – Clinical treatment in hospital Case reference 201501062 - Report issued in March 2016

Mr B complained about the standard of care provided to his late sister, Ms C when she had surgery and underwent chemotherapy for breast cancer. She sadly died as a result of the chemotherapy treatment. He complained that Ms C had been discharged from hospital too soon following surgery, the district nursing care provided post operatively was variable and whether the risks of the treatment had been fully explained to Ms C as part of the process for consenting to the treatment.

The Ombudsman partly upheld the complaint. He found that:

- a) the standard of inpatient care and the decision to discharge Ms C were both reasonable. However, there were some shortcomings in care in that a psychological assessment should have been completed and a nutrition assessment on admission.
- b) it was impossible to judge the standard of district nursing care as Aneurin Bevan University Health Board (“the Health Board”) could not locate the district nursing records; this in itself was an injustice to Ms C’s family
- c) whilst there is some difference within the oncology community about the wording used on consent forms, in Ms C’s case it would have been appropriate to use the term life-threatening infection.

The Ombudsman recommended that the Health Board:

- a) provide a written apology to Ms C’s family
- b) make a financial payment of £750 to Ms C’s family to reflect the loss of Ms C’s district nursing notes
- c) conduct a review of the wording used in its consent forms for chemotherapy treatment to include, where appropriate, the possibility of ‘life-threatening’ infection
- d) put in place satisfactory procedures for the Health Board to retrieve district nursing notes when patients stop receiving district nursing services
- e) verify, via appropriate clinical records audit, that MUST and psychological assessments are being completed for patients when indicated.

Cardiff and Vale University Health board – Continuing Care

Case Reference 201501974 - Report issued in March 2016

Mr W complained that Cardiff and Vale University Health Board (“the Health Board”) had failed to administer properly a retrospective claim for NHS Funded Continuing Care (NHSFCC) for his late father, Mr T. In particular, he said that when the Independent Review Panel (IRP) set up by the Board accepted eligibility for funded care for a period of time, it was not clear from its decision letter what factors in his father’s health had led to this decision. As Mr W could not recall any significant changes in his father’s condition, he questioned whether Mr T should have been found eligible for funding much earlier than the date decided by the Health Board. He thought it was possible that Mr T was eligible for the entire time he was in care.

The Ombudsman determined that a decision letter from the IRP was insufficiently detailed and there were flaws in the evidence used to assess entitlement during the final period of Mr T’s time in care. These flaws were such that the Ombudsman recommended that the Health Board should reconsider his entitlement for this period, but did not need to do so for the earlier periods. The complaint was partly upheld.

The Ombudsman also recommended that the Health Board implement a number of administrative improvements. These included the need for detailed chronologies of clinical need, clarity about the differences between periods of eligibility and non-eligibility, and for user-friendly decision letters.

Aneurin Bevan University Health Board - Health - Clinical treatment in hospital

Case reference 201501821 – Report issued in March 2016

Ms G complained about the nursing care her late father, Mr G, received at the Royal Gwent Hospital. Ms G said nursing staff should have contacted her earlier when her father’s condition deteriorated, so that family could have been present during Mr G’s final moments.

The following aspects of the complaint were upheld:

- National Early Warning Score (NEWS - physiological observations) hourly observations were not carried out on Mr G and medical staff were not informed of an increase in Mr G’s oxygen requirement.
- Records about Mr G’s naso gastric (“NG”) feeding being stopped were unclear and there was no evidence the NG was examined on a regular basis.
- Nursing staff should have contacted Mr G’s family earlier.

The Ombudsman recommended that Aneurin Bevan University Health Board (“the Health Board”):

- a) apologise for these failings

- b) remind nursing staff that a NG tube should be checked on a regular basis and the importance of physiological observations, and
- c) share the findings of this report with nursing staff.

The Health Board agree to implement these recommendations.

Abertawe Bro Morgannwg University Health Board & a GP in the Abertawe Bro Morgannwg University Health Board area - Health - Clinical treatment outside hospital Case references 201408678 & 201408650 – Report issued in March 2016

Mr A complained that Abertawe Bro Morgannwg University Health Board (“the Health Board”) and the GP failed to properly monitor his late father’s (“Mr B”) prostate cancer levels by undertaking six monthly blood tests. Additionally, Mr A complained about the way his complaint was dealt with.

In 2003 Mr B was diagnosed with incurable prostate cancer and remained under the Health Board’s care until October 2008. Mr B’s prostate cancer care was then transferred to primary care to undertake six monthly blood tests to monitor Mr B’s prostate cancer levels. The investigation found that both health bodies acknowledged that Mr B did not receive his six monthly blood tests and his prostate levels were not monitored from January 2009 until May 2013, but neither accepted responsibility. There were no “shared care” arrangements between the Health Board and the Practice for monitoring a patient’s prostate cancer levels in 2008, the only arrangement was to administer the hormone injection to the patient.

The written information/guidance for the transfer of such patients from secondary care to primary care for monitoring purposes was limited, the process varied between both the different areas and health professionals involved in a patient’s care in terms of process and responsibility.

The Ombudsman concluded that in Mr B’s case, it was the “collective responsibility” of the GPs at the Practice to monitor Mr B’s prostate cancer levels during the relevant period. Both health bodies had implemented changes to their procedures and/or Policies for the monitoring of prostate cancer patients, like Mr B, to provide a degree of clarity about their respective requirements and responsibilities with the aim of avoiding a recurrence of such events. The Ombudsman also upheld Mr A’s complaints handling concerns against the Health Board. He recommended that both health bodies:

- a) apologise to Mr A, and
- b) to offer financial redress for the shortcomings identified in the report.

Both health bodies agreed to these recommendations.

NOT UPHELD

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case reference 201501493 – Report issued in January 2016

Mr C complained about the care and treatment he received at the Emergency Department, Princess of Wales Hospital on 2 March 2015 after he attended with chest pain.

The Ombudsman found that, overall, Mr C's care and treatment was of a reasonable standard and was in line with the relevant guidance for chest pain. He did not uphold the complaint.

A GP within the Hywel Dda University Health Board area – clinical treatment outside hospital

Case reference 201406309 – Report issued in January 2016

Mrs X complained that a GP failed to diagnose that her husband had suffered a stroke after he had fallen at a residential home, despite Mrs X pointing out that Mr X's speech was slightly slurred. The GP arranged for an ambulance to take Mr X for an X-ray and wrote an accompanying letter. Mrs X also complained that the letter should have been more detailed so that hospital staff could identify her husband had suffered a stroke. Mrs X had left the home and when she later returned, she immediately recognised that Mr X was unwell, an ambulance was called and conveyed him to hospital.

The GP said that when she saw Mr X he was not slurring his words; she recorded this at the behest of Mrs X. The GP said her clinical assessment did not find that Mr X had suffered a stroke. The GP's accompanying letter was based on her clinical findings at assessment. Mr X's condition subsequently changed and her observations were no longer valid. The Ombudsman's adviser considered that the GP's actions and her letter were reasonable.

The Ombudsman did not uphold the complaints.

Cwm Taf University Health Board - Other

Case reference 201405015 – Report issued in January 2016

Mr X complained about the standard of care provided to him by Cwm Taf University Health Board ("the Health Board"). Mr X was under the care of the local Community Mental Health Team (CMHT), which is a multi-disciplinary, multi-agency team. Mr X said that he was a vulnerable adult with both physical and mental health problems who was struggling to live independently in the community. Mr X considered that the care provided to him had been inadequate for his needs.

The investigation found that the Health Board had provided Mr X with the clinical service which his condition required and the care provided had been of a reasonable standard. The Ombudsman therefore did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board - Appointments/admissions/discharge and transfer procedures

Case reference 201502276 – Report issued in January 2016

Mrs A complained to the Ombudsman about a delay by Abertawe Bro Morgannwg University Health Board (“the Health Board”) in arranging for her to be seen in an ophthalmic clinic run by the Health Board. At the time she complained, Mrs A had been waiting nearly a year to see the Consultant about her cataract condition following a referral by her GP. During the course of the investigation, Mrs A received and attended an appointment with a Consultant Ophthalmologist. However upon, examination, the Consultant was unable to identify any significant evidence of a cataract.

The Ombudsman found that whilst the Health Board failed to provide a service within Welsh Government targets, there was no injustice to Mrs A since there was no evidence of her having the condition for which she was referred. Accordingly, he did not uphold the complaint.

A GP in the area of Abertawe Bro Morgannwg University Health Board - Clinical treatment outside of hospital

Case reference 201502728 – Report issued in January 2016

Ms G complained about the standard of care provided to her adult son, Mr H, by his GP. She raised concerns that there was insufficient intervention offered to Mr H in relation to mobility, weight loss and breathlessness/dizziness. She was concerned that Mr H received a GP home visit twice with symptoms of dizziness; however, not long after, Mr H suffered a heart attack at home and sadly died.

The Ombudsman obtained clinical advice on the complaint. The Ombudsman concluded that the care provided to Mr H had been reasonable in response to his presenting symptoms. There was no evidence that Mr H’s untimely death could have been prevented or that the GP care had been substandard. The Ombudsman did not uphold the complaint.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital

Case Reference 201502545 – Report issued in February 2016

Mrs Y complained that Betsi Cadwaladr University Health Board (“the Health Board”) had not properly investigated the complaint she had made about its failure to arrange a care plan for her following her discharge from hospital.

The Ombudsman found that the Health Board’s complaint response reflected entries in Mrs Y’s clinical records; these showed that members of staff believed Mrs Y to have said that she already had carers at home and did not need a care plan. The complaint response had been reasonable, and the Ombudsman did not uphold the complaint.

A GP in the area of Hywel Dda Local Health Board - Health - Clinical treatment outside hospital

Case Reference 201503194 – Report issued in February 2016

Miss A complained about her GP for failing to take action when she told him of her concerns about her son's mental health. Miss A said she feared her son might take his own life but that the GP just told her to take him to A&E or the Out of Hours GP service if his mental health appeared to deteriorate. Miss A said that the GP should have taken more positive action to intervene. Sadly, Miss A's son did take his own life a fortnight later.

The Ombudsman found that the GP was limited in what action he could take as Miss A's son was an adult, capable of making his own decisions about his healthcare needs. The Ombudsman concluded that it was appropriate for the GP to advise Miss A in the way he had and that he could not have actively intervened without Miss A's son first coming to see him. The Ombudsman did not uphold the complaint.

A complaint against GPs in the area of Betsi Cadwaladr University Health Board - Health - Clinical treatment outside hospital

Case Reference 201503293, 201503294, 201503295, 201503296 - Report issued in February 2016

Mr A complained that the GPs his late wife saw, from June 2011 to July 2012, had failed to recognise that various symptoms which she had displayed were indicators of the Burkitt's-like Non-Hodgkins Lymphoma with which she was diagnosed in July 2012. He complained that had a hospital referral been made at an earlier stage, his wife's prognosis might have been improved. Mrs A sadly died in May 2013.

The Ombudsman concluded that the clinical assessment, investigations and management plans by the GPs in response to Mrs A's symptoms were appropriate. The Ombudsman found the hospital referral to have been made appropriately and in a timely fashion. The Ombudsman did not uphold the complaint.

A GP Practice in the area of Aneurin Bevan University Health Board - Clinical treatment outside hospital

Case Reference 201500062 – Report issued in February 2016

Mrs X complained about the care and treatment her husband, Mr X, received from the GP Practice. Mrs X complained that the number of tablets Mr X was taking had affected his liver. Mrs X also complained that there had been a delay in diagnosing Mr X's oral thrush and that there had been poor communication with the family.

The Ombudsman found that the number and combination of medication given to Mr X was reasonable in order to control his pain and the associated side effects and that there was no evidence to suggest that the medication would have affected his liver. The Ombudsman also found no evidence to suggest that there had been a delay in identifying and treating Mr X's oral thrush. Finally the investigation found that

there were a number of attempts by the GP Practice to discuss Mr X's diagnosis and prognosis. Therefore the complaint was not upheld.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case reference 201503199 - Report issued in March 2016

Mrs B's solicitor complained on her behalf about the care and treatment she received at Ysbyty Ystrad Fawr in September 2014 when she attended following a fall in which she sustained an injury to her foot. He specifically complained that there was a failure to identify that Mrs B had sustained a fracture to her foot.

The Ombudsman found that the assessment, examination and advice provided to Mrs B was appropriate and in line with good practice and that the evidence did not support Mrs B's complaint that there was a failure to identify a fracture. He did not uphold Mrs B's complaint.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case reference 201503266 - Report issued in March 2016

Mrs A complained about her late husband's care and management in the period prior to his death when he was seen by the Out of Hours GP Service ("the GPOOH Service") and at a later date Morriston Hospital's Emergency Department ("ED"). A post-mortem carried out following Mr A's death at home established that he had died of a perforated bowel. Mrs A was concerned that her husband's perforated bowel was not identified before his death. Mrs A was also dissatisfied with the way the Health Board had dealt with her complaint.

The Ombudsman having considered the advice provided by his Clinical Advisers concluded that both the OOHGP and ED care was reasonable and there was no reason to have considered a bowel perforation. These aspects of Mrs A's complaint were not upheld.

Finally, the Ombudsman did not uphold Mrs A's complaint concerning Abertawe Bro Morgannwg University Health Board's handling of her complaint.

Cwm Taf University Health Board – Continuing Care

Case reference 201501414 - Report issued in March 2016

Mrs A complained about the consideration of her family friend, Mrs B's, application for NHS funded continuing healthcare ("CHC") by Cwm Taf University Health Board's Independent Review Panel ("the IRP").

The Ombudsman found the IRP followed the procedure set out in Welsh Government guidance, considered all the available evidence and had applied the relevant tests in reaching its decision that Mrs B was not eligible for CHC. As there was no evidence of maladministration in the IRP's consideration of the application, the Ombudsman did not uphold the complaint.

Abertawe Bro Morgannwg University Health Board – clinical treatment in hospital
Case reference 201503343 - Report issued in March 2016

Mr A complained that damage caused during a biopsy operation resulted in additional surgery and an extended stay in hospital. Mr A said that this caused him discomfort, including a continuous cough and chest pain.

The Ombudsman found that the damage caused was a recognised risk of the biopsy operation and was appropriately repaired. There was no evidence of surgical shortcomings. The Ombudsman found Mr A had a pre-existing cough and that whilst the surgery may have caused some mild chest pain, this was not due to any inadequacy in his care.

The Ombudsman did not uphold the complaint.

Cwm Taf University Health Board - Appointments/admissions/discharge and transfer procedures
Case reference 201501427 - Report issued in March 2016

Mr B complained to the Ombudsman about the way in which Cwm Taf University Health Board (“the Health Board”) decided, while Mr B was detained under the Mental Health Act, that he should be placed in a 24 hour supervised facility instead of being allowed home to his flat. He complained that the Health Board did not do enough to explore alternative support to enable him to remain within his home.

The Ombudsman found no evidence that the Health Board had failed to assess Mr B properly, and that the decision to place Mr B in a 24 hour supervised facility was made in Mr B’s best interests. The Ombudsman concluded that it was reasonable for the Health Board to have arrived at this decision because there was evidence that Mr B was vulnerable and at risk if he remained in his flat – even with additional support.

The Ombudsman did not uphold the complaint.

Betsi Cadwaladr University Health Board and a GP Practice in the Betsi Cadwaladr University Health Board area – clinical treatment outside hospital

Case reference 201409628 & 201409629 - Report issued in March 2016

Mrs X complained that there was a delay in referring her late husband for a chest X-ray despite a number of visits to his GP Practice. He was referred for an X-ray in March 2013 and was found to have an aggressive lung cancer.

Mrs X also complained that there was a failure, by both Betsi Cadwaladr University Health Board (“the Health Board”) and the GP Practice, to investigate and manage Mr X’s neck pain, despite him complaining about this issue to clinicians from both bodies over a period of months. In late September, a scan found the tumour causing the neck pain, which was pressing on his spinal cord. Mrs X said that when the tumour in the neck was found, Mr X’s neck pain was managed much better than it had been. Sadly, Mr X died in October 2013.

The investigation found that there had been a delay in referring Mr X for a chest X-ray, but, in the circumstances, the delay had caused no detrimental effect on the outcome. Also, the treatment for the cancer would have been the same even if the delay had not happened.

The investigation found that there had been a delay in investigating Mr X's neck pain, but that delay had not been as a result of unreasonable care on the part of the clinicians involved (apart from one instance where a Health Board clinician should have investigated the neck pain in August). Given the characteristics of the tumour, it was unlikely that it would have been found significantly sooner than it was even if it had been investigated. Both complaints were not upheld.

Betsi Cadwaladr University Health Board - Clinical treatment in hospital

Case Reference 201501122 - Report issued in March 2016

Mrs P complained about her pregnancy management and care which she said resulted in the still birth of her baby daughter. Mrs P was a Type 1 diabetic and a planned Caesarian section ("C-section") had been planned for this, her fourth pregnancy, as with the earlier births. Mrs P complained that she had been inappropriately discharged from an earlier hospital admission, an earlier intervention should have occurred and her C-section delivery performed sooner. She also complained about the delay in her being seen by anyone on the day she was admitted to hospital again (when attending for a planned steroid injection) being when, it was later found, her baby had died.

Following a review of the clinical records, and seeking advice from two of the Ombudsman's Professional Advisers, the complaint was not upheld. Mrs P was found to have received appropriate clinical care throughout her pregnancy through a joint Obstetric and Diabetic clinic in accordance with national guidance. Efforts had been made to control her blood sugars which had not been well controlled throughout. There had been no clinical reason not to discharge Mrs P (after monitoring) when she was admitted over a month earlier. On the day in question, Mrs P was attending as planned, but admitted when she complained of suffering abdominal pain for three days previously. The Ombudsman agreed that Mrs P should have been seen earlier that day for proper assessment, and had not been as the ward was very busy (reflected by many retrospective nursing entries). This was a record keeping concern and a staffing issue. He was concerned that some mechanisms be put into place in that regard to ensure patients such as Mrs P did not suffer such delays in future.

However, there was no way of knowing when, why, or what happened to lead to the sad, unpredicted outcome for Mrs P. There had been no clinical indication for any earlier intervention or delivery as Mrs P had complained. On the professional advice received, there was nothing to warrant this. Clinicians had to balance the risk to both mother and baby when taking such decisions and there was, on the evidence, no basis to criticise their decisions in this case.

Despite not upholding Mrs P's complaints, in light of the issues highlighted, the Ombudsman made the following recommendations, which Betsi Cadwaladr University Health Board agreed to implement in full:

- a) to apologise to Mrs P for the failure identified on the day itself
- b) to undertake within a month a review of staffing levels on the ward (and all its maternity wards) to ensure minimum safe staffing levels at midwife levels and sufficient doctor presence. It should report on the outcome of that review to the Ombudsman one month thereafter
- c) if deficiencies were highlighted by the review, it should prepare an action plan to deal with the issue and present this to the Ombudsman within three months

d) within two months the Director of Nursing should undertake a sample review of midwifery records to assess their quality and identify any resulting action required. A report on the outcome of that exercise is to be shared with the Ombudsman a month thereafter.

Cwm Taf University Health Board - Clinical treatment in hospital

Case Reference 201502262 – Report issued in March 2016

Mr S complained about the care and treatment that his late wife had received at the Royal Glamorgan Hospital. Mrs S was being treated for Non Hodgkin Lymphoma. Sadly the treatment was not as effective for her as had been anticipated and she died having developed a pulmonary embolism. Mr S was concerned that there had been delays that had compromised her treatment and that staff dealing with her were not sufficiently experienced in dealing with her condition.

Professional advice was obtained from an experienced haematologist. It was explained that patients having chemotherapy are at risk of developing an embolism, despite being on preventive medication. The Adviser could not identify any failings in care and treatment.

Having considered the information and advice available, the Ombudsman could not find any shortcomings in the care and treatment that Mrs S had been given and consequently the complaint was not upheld.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Reference 201503015 – Report issued in March 2016

Mrs F complained about the care and treatment she had received for a hernia. She said that she had waited 38 weeks for an operation to repair the hernia and believed that this may not have been performed correctly because the hernia repair failed soon after. She had to wait 33 weeks before a second operation took place. She believed that she had been in pain and discomfort for longer than necessary.

The Ombudsman considered the advice of his Professional Adviser who viewed the case within the context of the Welsh Government target that treatment should be provided within 26 weeks for 95% of cases, with a maximum of 36 weeks for the remainder. He noted that all patients awaiting surgery for a hernia condition will be in some degree of pain and discomfort. Although the waiting times were not ideal, the Adviser could not identify any clinical reason why Mrs F should have been seen sooner than other patients on the waiting list. He did not find any clinical shortcomings in the care and treatment that Mrs F had received.

Abertawe Bro Morgannwg University Health Board provided information about its plans to reduce waiting lists. The complaint was not upheld.

Hywel Dda University Health Board – clinical treatment in hospital

Case Reference 201502260 – Report issued in March 2016

Mrs J said her cousin Miss E sustained an ankle injury, was admitted to A&E at Withybush Hospital and operated on; 13 days after being discharged Miss E attended another hospital and sadly died. Her cause of death was recorded as Pulmonary Embolism (PE) and classified as a hospital acquired thrombosis. Mrs J complained that on discharge Miss E had not been considered as being at risk of PE nor administered thromboprophylaxis (used to prevent the development of a blood clot). Mrs J also complained Hywel Dda University Health Board ("the Health Board") described Miss E's injury as not being complicated, but the radiology report contradicted this. Mrs J was unsure Miss E could be said to be mobile on discharge.

The Ombudsman found that the Health Board had considered Miss E to be at risk of suffering PE on discharge and had no criticism that Miss E had not been administered thromboprophylaxis on discharge as the guidelines are unspecific. The Health Board accepted and apologised for the fact that Miss E's injury had been more complicated than described. Miss E had passed a physiotherapy mobility test on discharge. The complaint was not upheld.

A GP in the Betsi Cadwaladr University Health Board area - Clinical treatment outside hospital

Case Reference 201501030 – Report issued in March 2016

Mr D complained that the GP failed to undertake a physical examination of his late father, Mr G, during a home visit. Mr D complained that this caused a delay in the diagnosis of Mr G's chest infection and his resulting pneumonia, which was his recorded cause of death five days later.

The investigation found that the GP's home visit was to discuss Mr G's reduced and progressively deteriorating mobility, together with his ongoing symptoms of back pain. In the circumstances of the complaint the Ombudsman concluded that the GP's decision not to physically examine Mr G was reasonable. Secondly, Mr G displayed no symptoms indicative of a chest infection, none were observed by the GP and no such symptoms were reported to the GP at the home visit. The investigation concluded that in these circumstances there was no reason for the GP to have carried out a respiratory examination on Mr G, and this decision was clinically reasonable. Mr D's complaint was not upheld.

A GP in the Betsi Cadwaladr University Health Board area - Clinical treatment outside hospital

Case Reference 201501030 – Report issued in March 2016

Mr D complained that the GP failed to undertake a physical examination of his late father, Mr G, during a home visit. Mr D complained that this caused a delay in the diagnosis of Mr G's chest infection and his resulting pneumonia, which was his recorded cause of death five days later.

The investigation found that the GP's home visit was to discuss Mr G's reduced and progressively deteriorating mobility, together with his ongoing symptoms of back pain. In the circumstances of the complaint the Ombudsman concluded that the GP's decision not to physically examine Mr G was reasonable. Secondly, Mr G displayed no symptoms indicative of a chest infection, none were observed by the GP and no such symptoms were reported to the GP at the home visit. The investigation concluded that in these circumstances there was no reason for the GP to have carried out a respiratory examination on Mr G, and this decision was clinically reasonable. Mr D's complaint was not upheld.

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Cwm Taf University Health Board - Clinical treatment in hospital **Case Reference 201504415 – Report issued in January 2016**

With the assistance of her Community Health Council advocate, Mrs E complained that the lessons had not been learnt by Cwm Taf University Health Board (“the Health Board”) from failings identified in the care provided to her late husband prior to his death at Royal Glamorgan Hospital. In particular Mrs E expressed concern that action points relating to the failings discussed during a meeting with the clinicians and concerns team had been ineffective. Mrs E complained also that the Health Board cancelled and rearranged a meeting with her on two occasions and at short notice.

On receipt of the complaint the Health Board were asked to:

- a) provide Mrs E with a meaningful apology for the failings identified during the meeting and to provide details of the implementation and effect of the action points to demonstrate that lessons had been learnt
- b) apologise to Mrs E also for the inconvenience and delay caused by its complaint handling and
- c) to make a time and trouble payment in the sum of £250 in respect of the inconvenience and delay caused by the cancellations.

The Health Board agreed to comply with these requests within one month.

Cwm Taf University Health Board – Clinical treatment in hospital **Case Reference 201504243 – Report issued in January 2016**

In November 2014, Mr E complained to Cwm Taf University Health Board (“the Health Board”) about the standard of care and treatment that he received whilst a patient at the Royal Glamorgan Hospital. Mr E complained to the Ombudsman that the Health Board had failed to respond to his letter of complaint. On receipt of the complaint, the Ombudsman contacted the Health Board to discuss Mr E’s concerns. The Health Board agreed to resolve the complaint on the following basis:

- a) to provide a detailed response to the concerns which Mr E raised with the Health Board
- b) To apologise for the significant delay in respect of providing the response
- c) to make an offer of £250 by way of apology in recognition of the delay in responding.

Hywel Dda University Health Board - Clinical treatment in hospital **Case reference 201504804 – Report issued in January 2016**

In January 2014, Mrs F complained to Hywel Dda University Health Board (“the Health Board”) about her husband’s care in Withybush General Hospital. Mrs F complained to the Ombudsman that the Health

Board had failed to respond to her concerns and there had been limited contact from the Health Board. Mrs F complained that the Health Board failed to manage her complaint appropriately.

On receipt of the complaint, the Ombudsman contacted the Health Board to discuss Mr F's concerns. The Health Board agreed to resolve the complaint on the following basis:

- a) to provide a response to the concerns which Mrs F raised with the Health Board
- b) to apologise for the significant delay in respect of providing the response
- c) to make an offer of £250 in recognition of the distress and anxiety that had been caused as a result of the delay.

Abertawe Bro Morgannwg University Health Board – Clinical treatment outside hospital Case reference 201504294 – Report issued in January 2016

Mrs T complained that she was not given adequate support by Abertawe Bro Morgannwg University Health Board ("the Health Board") when her husband agreed to undertake a Home Care Dialysis programme in December 2014. She also complained about a number of other issues including incorrect diagnosis, treatment and the use of Welsh by staff to converse with each other in their presence at Morriston Hospital Renal unit.

It was discovered that the Health Board had responded to her complaints. The Ombudsman recommended that the Health Board write to Mr & Mrs T within 20 working days of the date of this letter and offer a date for a local resolution meeting with its renal team to review any outstanding issues and review Mr T's ongoing treatment.

The Health Board agreed to this.

Cwm Taf University Health Board - Other Case Reference 201503624 – Report issued in January 2016

Mr E complained after Cwm Taf University Health Board ("the Health Board") failed to carry out actions previously agreed with the Ombudsman under case reference number 201500483.

After further consideration and discussions with the Health Board it wrote to Mr E with a full response to his complaint, apologies and financial redress for the time and trouble experienced in making his complaint.

The Ombudsman considered that the action taken by Health Board was reasonable and resolved this complaint.

Hywel Dda University Health Board - Clinical treatment in hospital Case Reference 201504473 – Report issued in January 2016

Mrs G complained that she submitted a complaint to Hywel Dda University Health Board ("the Health

Board”) in October 2013, regarding the care and treatment provided to her late husband, but at the time of approaching the Ombudsman in November 2015 she had not received a response from it.

On receipt of this complaint, the Ombudsman contacted the Health Board which agreed to send a response to Mrs G together with its apologies for the delays she has experienced. Mrs G received a letter dated 4 January 2016.

Cardiff and Vale University Health Board - Patient list issues

Case Reference 201504554 – Report issued in January 2016

Ms B’s complaint was about the care and treatment she received at the Accident and Emergency Unit while attending in severe pain, after a fall. She complained that after undergoing an x-ray she was told her shoulder needed surgery but during an eight day period she said she received no medical intervention other than the x-ray, a sling and Co-Codamol.

Ms B also complained that after surgery had been scheduled it had been cancelled the day before and, therefore, as she was in so much pain she sought the surgery privately. She said that private funded consultant told her that her shoulder could not be saved and that she now has 80% mobility in her right shoulder.

On receipt of this complaint, the Ombudsman contacted the Health Board. The Ombudsman was advised that Ms B was contacted on 4 January 2016 with an apology for the delay in providing treatment and asking for documentation in support of the costs incurred in seeking private treatment to consider financial redress. Ms B confirmed that she was happy with the action that the Health Board had said it would take.

Public Health Wales - Clinical treatment outside hospital

Case Reference 201504581 - Report issued in January 2016

Ms S complained that in preparation of having a wire guided biopsy, a Radiologist injected a local anaesthetic into the side of her left breast to insert a wire. Ms S said that the Radiologist tested the area and, although she said she advised there was still some feeling, he proceeded with the procedure. She said that the procedure caused her a huge amount of pain and discomfort.

Public Health Wales (“the Health Authority”) gave an explanation of the Radiologist’s account of the events and why he could not stop the procedure once the needle had been inserted. It also acknowledged that the procedure should have been clearly explained to her and that the Radiologist apologised that the examination was traumatic and regrets that she felt ignored. He also recognised that waiting slightly longer for the anaesthetic to take effect may have reduced pain and discomfort.

In light of the Health Authority acknowledging its shortcomings, it agreed to offer Ms S a financial redress in the amount of £300 in recognition that the pain and discomfort she had experienced may have been reduced if the Radiologist waited slightly longer for the anaesthetic to take effect.

The Ombudsman considered that the action which the Health Authority said it would take was reasonable and would resolve this complaint, and therefore he considered the matter to be settled. However, Ms S was advised to come back to the Ombudsman if the action promised by the Health

Authority did not materialise or was unsatisfactory.

Hywel Dda University Health Board - Appointments/admissions/discharge and transfer procedures

Case Reference 201505331 – Report issued in January 2016

Mr L complained about the length of time it had taken the Health Board to carry out his hip operation. Mr L underwent surgery in December 2015. On receiving the complaint the Ombudsman contacted Hywel Dda University Health Board (“the Health Board”) and it confirmed that it had received some communications from Mr L which it had dealt with informally.

The Health Board agreed to arrange a meeting with Mr L to discuss any outstanding concerns to try and resolve issues.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case reference 201504019- report issued in January 2016

Mr A's son was born with a congenital abnormality where a portion of skin was missing from the scalp. Mr A did not accept his son had this condition and complained that the midwife delivering his son had used a tongue depressor during his birth which caused a cut on his head.

Aneurin Bevan University Health Board (“the Health Board”) accepted the Ombudsman's proposal to refer Mr A's son for a second opinion. Given this, the Ombudsman considered the action that the Health Board had agreed to take was reasonable and the matter resolved.

Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case reference 201503912 – report issued in January 2016

Mr S complained about Abertawe Bro Morgannwg University Health Board's (“the Health Board”) handling of his complaint. Mr S experienced difficulties corresponding with the Health Board by e-mail and approached the Ombudsman for assistance, as he initially made a complaint in 2014.

The Ombudsman noted that the Health Board had made attempts to contact Mr S but it had also experienced similar difficulties. In light of this, the Investigation Officer concluded that Mr S's complaint required consideration and a final response. The Health Board agreed to the following recommendations:

- a) to respond to Mr S complaint dated 1 September 2015, in line with its usual procedures
- b) to provide a response in writing, in light of previous e-mail difficulties.

Betsi Cadwaladr University Health Board - Other

Case Reference 201501779 – Report issued in February 2016

Mrs X complained that Betsi Cadwaladr University Health Board ("the Health Board") failed to correctly diagnose her illness for over four years. It also failed to provide her with appropriate treatment by way of "talking therapy" or Cognitive Behavioural Therapy ("CBT"). She said that she had had to seek this treatment privately which she should not have had to do. Mrs X wanted the Health Board to place her on a CBT course and to refund the cost of her private treatment in order to resolve her complaint.

The Ombudsman sought clinical advice on the complaint from a Consultant Psychiatrist ("the Adviser"). The Adviser noted that Mrs X's diagnosis had not been agreed between her and the Health Board. The Adviser said that it was not possible to reach any firm conclusions as to whether the assessment of Mrs X's condition was reasonable or appropriate given that the diagnosis remained in dispute. He could however say that whilst CBT would have been appropriate treatment, it was reasonable that Mrs X had not been offered CBT by the Health Board until November 2014, given her clinical presentation at the time.

As Mrs X indicated that she still wished to undergo CBT, the Health Board prioritised her treatment. The Health Board agreed to seek a second opinion for Mrs X, given the Adviser's view that this may assist with the diagnosis disagreement. The Ombudsman considered that these two actions amounted to a reasonable settlement of the complaint.

A GP surgery in the area of Abertawe Bro Morgannwg University Health Board - Clinical treatment outside hospital

Case Reference 201504201 – Report issued in February 2016

Mrs B complained that a doctor at the practice had acted in a manner which was disrespectful and discourteous. As a consequence she reluctantly left the practice.

The practice agreed that:

- a) the doctor concerned would write to Mrs B and apologise
- b) the doctor would refer the incident to his supervisor at his next appraisal, and
- c) the practice would pay £250 to Mrs B in recognition of the distress caused by the incident and the time and trouble taken to pursue the complaint.

Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case Reference 201408758 – Report issued in February 2016

Mr X complained that Abertawe Bro Morgannwg University Health Board ("the Health Board") failed to X-ray his spine after he had fallen from a tree in his harness when working as a tree surgeon in 2013. When he visited the Princess of Wales Hospital's Emergency Department shortly after the fall, he was assessed by a doctor who prescribed painkillers and provided him with a back injury leaflet. Mr X said that he was told the injury was muscular. An X-ray undertaken months later found a minor wedge fracture of a thoracic vertebra (a vertebra in the middle of the spine) and reduced disc spacing on either side of the vertebra.

The investigation found that the assessment undertaken by the doctor was reasonable and that it had been reasonable not to refer Mr X for an X-ray of his spine during that visit. The complaint was therefore not upheld.

Powys Teaching Health Board - Other

Case reference 201501179 – Report issued in February 2016

Mrs A complained to the Ombudsman about a Psychologist employed by Powys Teaching Health Board ("the Health Board") failing to disclose information pertaining to her daughter's safety. He also made a referral to Social Services without Mrs A's consent. Mrs A also had concerns about an assessment completed by the Psychologist and his failure to disclose a copy to her.

On the Ombudsman's request, the Health Board agreed, as the Psychologist had left its employment and relocated abroad, to review Mrs A's case to facilitate discussion and reflective learning, with any lessons identified being discussed at an appropriate meeting and required actions implemented.

Hywel Dda University Health Board – Clinical treatment in hospital

Case reference 201505686 - Report issued in February 2016

Ms G complained that eight months after submitting a complaint to Hywel Dda University Health Board ("the Health Board") concerning the care provided to her late mother which led to her possible preventable death, she had still not received a response.

On receipt of this complaint, the Ombudsman contacted the Health Board which agreed to the following actions:

- a) to provide Ms G with an immediate apology, explanation and update, and
- b) offer financial redress in the sum of £100 in recognition of its failure to keep her updated.

Hywel Dda University Health Board – Clinical treatment in hospital

Case reference 201505748 - Report issued in February 2016

Miss X complained about the management and handling of her complaint by Hywel Dda University Health Board ("the Health Board") in relation to the difficulties and pain experienced due to its failure to diagnose and treat her kidney.

On receipt of this complaint, the Ombudsman contacted the Health Board which agreed to undertake the following actions:

- a) write to Miss X apologising for the delays incurred and to update her with its current position
- b) offer financial redress in recognition of its failings, and
- c) provide a full response.

Abertawe Bro Morgannwg University Health Board – Patient list issues

Case reference 201505508 - Report issued in February 2016

Mrs I complained about the treatment received at the Princess of Wales Hospital, Bridgend in respect of a hernia repair in April 2014. In particular, Mrs I complained that the operation did not resolve her pain and she developed asymmetry of the abdomen. Also, she was not aware that her care had been transferred to another consultant.

Abertawe Bro Morgannwg University Health Board (“the Health Board”) responded to Mrs I’s initial complaint in June 2015, but Mrs I was dissatisfied and sent a further letter on 16 August 2015, to highlight the points which had not been addressed. The Health Board did not respond because it believed that Mrs I had referred the matter to her legal team. The Health Board was not aware that Mrs I had subsequently decided not to do so.

On receipt of the complaint, the Ombudsman discussed the matter with the Health Board. The Health Board agreed to provide a response to the concerns raised in Mrs I’s letter.

Aneurin Bevan University Health Board – Clinical treatment in hospital

Case reference 201501401 - Report issued in February 2016

Mr A complained to the Ombudsman about clinical and nursing aspects of his father’s care at the Royal Gwent Hospital during two admissions between 29 April 2013 and 2 September 2013. He also raised concerns about Aneurin Bevan University Health Board’s (“the Health Board”) handling of his complaint, including its final decision that no redress was payable under the NHS complaints procedure.

The Ombudsman considered that an investigation of the care was unlikely to be of value as the Health Board had already identified a number of significant failings through its own investigations. However, he was not satisfied that the Health Board had done enough to acknowledge the extent of the failings or to demonstrate effective organisational learning from the complaint. The Ombudsman proposed the following voluntary actions to the Health Board which it agreed to undertake in settlement of the complaint:

a) Apologise to Mr A and pay him £350 in recognition of the poor handling of his complaint.

b) Make an additional payment of £500 to Mr A in recognition of:

- the poor communication with him during his father’s time in hospital
- the failure to involve him in his father’s discharge planning and rehabilitation at the time of his first discharge from hospital, and
- the distress caused by the acknowledged failings in his father’s care.

c) Recognise and provide an appropriate apology to Mr A for its failure to:

- assess his father’s care needs properly on admission and to put in place an effective communication care plan that fully considered his needs as person with hearing loss and dementia
- make reasonable adjustments to the way in which it provided services for his father in order to accommodate his hearing loss
- maintain appropriate assessments relating to mouth care and to recognise his father’s need for mouth

care support.

d) Provide Mr A with information about the work it had undertaken with Action on Hearing Loss Wales and an update on the Health Board's progress towards achieving the All Wales Standards for accessible communication for patients with sensory loss.

e) Provide Mr A with a final response to his complaint about the operation of the Health Board's Redress Panel.

f) Share with Mr A an up-to-date action plan arising from the findings of its own complaint investigations.

Hywel Dda University Health Board – Clinical treatment in hospital

Case reference 201505930 – Report issued in February 2016

Ms A complained to Hywel Dda University Health Board ("the Health Board") in June 2014 about the treatment that her child had received. Ms A then complained to the Ombudsman in January 2016 due to the lack of response or update from the Health Board during the course of its investigation.

The Ombudsman found that the delay in responding to Ms A's complaint was excessive and the lack of updates amounted to maladministration.

Hywel Dda University Health Board agreed to:

a) pay Ms A £300 for the extreme delay and lack of updates in dealing with the complaint

b) send an apology to Ms A

c) provide Ms A with a meaningful explanation for the delay and lack of updates

d) provide Ms A with a timescale for when the investigation will be completed and the formal response issued.

Cwm Taf University Health Board – Clinical treatment in hospital

Case reference 201504941 - Report issued in February 2016

With the assistance of her Community Health Council advocate, Mrs E raised a number of issues about the care and treatment provided to her late brother at Prince Charles Hospital. In particular Mrs E questioned whether decisions to discharge and offer radiotherapy treatment was appropriate. Cwm Taf University Health Board ("the Health Board") responded to the majority of issues raised and acknowledged some failings in respect of non-completion of food charts and some incidences of a lack of communication with the family. Mrs E also questioned whether there had been any change in practice in consequence of the poor communication.

Having considered the complaint, the Ombudsman recommended that the Health Board:

a) consider and respond to the concerns raised about the decision to offer radiotherapy as these had not been previously addressed

b) provide further comment to Mrs E in respect of her concerns about the decision to discharge.

c) undertake an audit of current practice on the ward concerned to ensure appropriate communication with patients' families. The findings of this audit will be shared with this office together with any associated action plan.

The Health Board agreed to comply with these recommendations.

Betsi Cadwaladr University Health Board - Appointments/admissions/discharge and transfer procedures

Case Reference 201505450 – Report issued in March 2016

The Ombudsman received a complaint from Ms X because Betsi Cadwaladr University Health Board ("the Health Board") did not provide an appointment within the recommended two week target set for urgent GP referrals.

Ms X was offered an appointment after the urgent referral was downgraded on clinical triage. An additional delay occurred when the first appointment was rescheduled to the following week. Ms X became anxious about the delay and decided to attend a private consultation.

The Health Board acknowledged that on this occasion, it did not meet the recommended national guidelines and provide Ms X with an earlier appointment. The Health Board agreed to:

- a) apologise to Ms X for the delay
- b) pay Ms X the sum of £250 in recognition of the anxiety and inconvenience caused by the delay

Aneurin Bevan University Health Board - Continuing care

Case Reference 201506210 – Report issued in March 2016

Mr G complained about the low standard of written correspondence he had received from Aneurin Bevan University Health Board ("the Health Board"). In addition, he was unhappy at the date from which his late mother was assessed by the Health Board to be eligible for continuing health care.

Following consideration of the complaint, the Ombudsman contacted the Health Board to discuss Mr G's concerns. He found that the Health Board's written correspondence with Mr G had at times been poor. He also found that Mr G had not formally reviewed the Health Board's continuing health care assessment decision.

The Ombudsman recommended that the Health Board:

- a) remind all staff to double check content and proof read letters
- b) consider and review standard letter templates with a view to making them clearer to the public, and
- c) facilitate an independent retrospective review of Mr G's late mother's continuing health care.

The Health Board agreed to carry out the recommendations.

Cardiff and Vale University Health Board - Clinical treatment in hospital Case Reference 201506221 – Report issued in March 2016

Mr Q complained about the care and treatment that his father had received at the University Hospital Wales. Mr Q said that there had been an unacceptable delay in his feeding tube being replaced. Mr Q's concerns were logged but he did not receive a response to his complaint for 12 months. During this time, Mr Q requested his father's medical records but these were not supplied. Mr Q was also disappointed in Cardiff and Vale University Health Board's (the Health Board") complaint response.

Following consideration of the complaint, the Ombudsman contacted the Health Board to discuss Mr Q's concerns. The Ombudsman asked the Health Board to do the following:

- a) provide Mr Q with his father's medical records as soon as possible
- b) write a letter of apology for the 12 month delay in responding to the initial concerns he raised in January 2015, and
- c) make an ex-gratia payment of £150 for the time and trouble in making, following up and waiting for the complaint response.

The Health Board agreed to carry out the requested actions.

Abertawe Bro Morgannwg University Health Board - Continuing care Case Reference 201506251 – Report issued in March 2016

Mrs H complained via her Solicitor about the retrospective Continuing Healthcare Assessment undertaken by Abertawe Bro Morgannwg University Health Board ("the Health Board") on behalf of her late mother. Mrs H was unhappy with the decision that her late mother was not eligible for funding. Also, she complained that an Independent Review Panel was not convened to consider the case further. Following consideration of the complaint, the Ombudsman found that the Health Board had followed due process in assessing Mrs H's late mother's care needs; however, insufficient information was given as to why an Independent Review Panel was not arranged.

Accordingly, the Ombudsman contacted the Health Board to discuss Mrs H's concerns and asked it to arrange for an independent review of Mrs H's case and ensure a detailed response was given outlining the decision reached.

The Health Board agreed to carry out the recommendation.

Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Reference 201505058 – Report issued in March 2016

Mrs B complained that Betsi Cadwaladr University Health Board ("the Health Board") had failed to ensure that she had follow up care and treatment after she underwent radio iodine treatment for a hyperthyroid condition. She also complained that the Health Board had taken an unreasonable amount of time to deal with her complaint.

The Ombudsman found that the care and treatment provided to Mrs B was reasonable and this part of her complaint was not upheld. The matter relating to unreasonable delays by the board in dealing with her complaint was upheld and the Ombudsman recommended that the Health Board:

Complaints handling

UPHELD

Hywel Dda University Health Board & Powys Teaching Local Health Board - Health Case Reference 201501208 & 201501776 – Report issued in February 2016

Mr and Mrs F complained that there was significant delay by both Health Boards in providing treatment for their daughter G and that their concerns were not taken seriously. They also complained about the delay in responding to their complaint.

G was treated within the referral to treatment time specified in Welsh Government guidance for non urgent cases. The Ombudsman's Medical Adviser said that diagnosis and treatment by the Consultant Paediatrician were reasonable. Therefore this element of the complaint was not upheld.

The family were not adequately informed of reasons for the delay in dealing with the complaint and this element of the complaint was upheld. Hywel Dda University Health Board was responsible for co-ordinating the complaint response. It agreed to pay Mr and Mrs F £100 to recognise that it failed to keep the family updated during the complaints process.

Quick fixes and voluntary settlements

Hywel Dda University Health Board – Complaints Handling Case reference 201505031 – report issued in January 2016

Mr X complained about the lack of communication and final response from Hywel Dda University Health Board ("the Health Board") after making a complaint in June 2015.

On receipt of the complaint, the Health Board was contacted and subsequently provided its final response to Mr X.

Abertawe Bro Morgannwg University Health Board – Complaints Handling Case reference 201504338 – report issued in January 2016

Ms A complained that a further complaints meeting to review her concerns about the care and treatment provided to her father, Mr A, during his admission to the Princess of Wales Hospital in September 2014 had not been arranged by Abertawe Bro Morgannwg University Health Board ("the Health Board").

Having considered the information provided on behalf of the complainant, the Ombudsman approached the Health Board on the basis that it appeared that although a number of informal complaints meetings had previously been held to discuss Ms A's concerns, the Health Board had not yet provided Ms A with a formal complaints response nearly one year later. The Health Board agreed to settle the complaint by providing a formal written response addressing the specific issues of Ms A's complaint and also by providing Ms A with a redress payment of £250 in recognition of the time and trouble caused due to the delays that had occurred in its complaints handling process.

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

Abertawe Bro Morgannwg University Health Board – Complaints Handling Case Reference 201504821 – Report issued in January 2016

Ms A, via her advocate, complained about the length of time that she had been waiting for a response to her complaint to Abertawe Bro Morgannwg University Health Board (“the Health Board”).

Having considered the information provided on behalf of the complainant, the Ombudsman approached the Health Board on the basis that it appeared that there had been an excessive delay in providing a response. The Health Board provided evidence to confirm that it had provided its complaints response in December 2015. In this letter, the Health Board had apologised and explained the reasons for the delay. In addition, it offered Ms A a redress payment of £250 in recognition of the time and trouble caused to her due to the delays that had occurred in its complaints handling process.

The Ombudsman concluded that the action which the Health Board had taken was reasonable to settle the complaint and closed the file on this basis.

Hywel Dda University Health Board – Complaints handling Case Reference 201504754 – Report issued in January 2016

Mr D stated that Hywel Dda University Health Board (“the Health Board”) had failed to provide him with a response in a timely manner. Mr D said that he was still awaiting a final response.

After the Ombudsman contacting the Health Board, it responded to Mr D’s complaint in a letter dated 16 December 2015.

Betsi Cadwaladr University Health Board – Complaints handling Case Reference 201504820 - Report issued in January 2016

Mrs W complained that Betsi Cadwaladr University Health Board (“the Health Board”) had failed to provide her with a response in a timely manner. Mrs W said her original complaint was dated August 2015. Mrs W also stated that the Health Board failed to send a ‘holding letter’ after the 30 day period ended to inform her of any further delay.

The Ombudsman contacted the the Health Board and it said a response to Mrs W’s complaint was being sent to her. This would include an apology for the length of time it has taken to consider the complaint and an apology for the lack of communication (holding letters) after the 30 day period, informing Mrs W of further delays.

Hywel Dda University Health Board – Complaints handling Case Reference 201504477 – Report issued in January 2016

Mrs W complained that she submitted a complaint to the Health Board on 11 September 2014 but at the time of making a complaint to the Ombudsman, on 11 November 2015, she had still not received a response from it.

On receipt of this complaint, the Ombudsman contacted Hywel Dda University Health Board which agreed to provide a full update and explanation of the progress of the complaint, along with an apology for the delay, by 19 January 2016. It also agreed to provide a full response and offer a financial redress payment of £250 in recognition of its delays.

Hywel Dda University Health Board – Complaints Handling Case Reference 201504886 – Report issued in February 2016

Ms X complained, on behalf of her late mother, Mrs X, that her GP mismanaged her anticoagulation medication and that clinicians at Glangwili Hospital failed to administer an antidote to reverse the anticoagulant action following her emergency admission with cerebral bleeding. Ms X also complained about excessive delay in the Health Board's handling of her complaints.

The Health Board investigated Ms X's complaint about her GP's management of medication and provided comments on the use of an antidote. However, the Health Board considered that it had not had an opportunity to investigate Ms X's concerns about other aspects of Mrs X's care and treatment at Glangwili Hospital as Ms X had not raised these concerns in her original letter of complaint.

The Ombudsman agreed that the Health Board should be given the opportunity to conduct an investigation of these matters.

Ms X agreed to this arrangement.

Hywel Dda University Health Board – Complaint Handling Case Reference 201503956 – Report issued in February 2016

Mr X complained, on behalf of his client, Mrs Y, about the inpatient care and treatment provided to her late mother between 16 April and 17 May 2013. He also complained about Hywel Dda University Health Board's ("the Health Board") failure to respond to his letter of 28 October 2014, which queried its response of 12 August 2014.

Given that Mr X clarified that he did not wish to pursue a clinical complaint, this aspect of the complaint was discontinued. In respect of the complaint handling, the Health Board agreed to pay £300. It also agreed to seek independent clinical advice on the complaint, which it would share with Mr X. The Ombudsman considered the Health Board's actions to amount to a reasonable settlement of the complaint and Mr X agreed. Accordingly, the complaint was settled.

Hywel Dda University Health Board - Health Case reference 201505019 - Report issued in February 2016

Mr & Mrs C complained that Hywel Dda University Health Board ("the Health Board") had failed to arrange a local resolution meeting after they had made a request in August 2015. The meeting was eventually held in January 2016. The nursing staff member present, however, was not in possession of a letter previously submitted by Mr & Mrs C, which outlined their concerns.

The Ombudsman recommended that the Health Board:

- a) write a letter of apology to Mr & Mrs C for the unreasonable delay

b) make an offer of £100 in recognition of the time and trouble taken by Mr & Mrs C in making their complaint.

The Health Board agreed to these recommendations.

North Wales Housing – Housing

Case reference 201504666 - Report issued in February 2016

Mr & Mrs B complained about several issues surrounding their tenancy of a property owned by North Wales Housing (“the Association”).

Their primary complaint was not considered suitable for investigation. Two elements of their complaint however were considered suitable for settlement by the Association. These related to the entry to their flat by a care worker at the housing complex and the breakdown of provision of uncooked food for their daily meals.

The Ombudsman recommended the following, which the Association agreed to undertake:

- a) send a letter of apology in relation to the two matters
- b) make an offer of an ex gratia payment of £100 for the unauthorised entry to the complainant’s home
- c) make an offer of £150 in recognition of the time and trouble taken to make a complaint
- d) offer the complainant a meeting with the chef manager to agree a daily ingredients list to cover a 7 day rota.

Betsi Cadwaladr University Health Board - Health

Case reference 201503785 - Report issued in February 2016

Mrs A and her sister complained about Betsi Cadwaladr University Health Board’s (“the Health Board”) processing of genetic test results relating to their late father and its procedures for genetic counselling. Concerns were also raised about unreasonable delays by the Health Board when considering their complaint.

Although the primary complaint was found to be out of time for the Ombudsman’s consideration, upon receipt, he contacted the Health Board about its complaint handling. The Health Board acknowledged that the complaint was not dealt with as it should have been and agreed to make a voluntary payment of £125 to each complainant in recognition of the undue delays and any inconvenience caused.

Betsi Cadwaladr University Health Board – Complaints Handling

Case Reference 201504667 – Report issued in March 2016

Mr X’s complaint concerned the delay by Betsi Cadwaladr University Health Board (“the Health Board”) in responding to a complaint concerning the treatment received by his mother, Mrs Y, in the Emergency Department at Glan Clwyd Hospital.

On receipt of the complaint, the Health Board was contacted and agreed to provide Mr X with a full response to the complaint, and also provide a payment of £250 in recognition of its failure to deal with the complaint in a timely manner and provide Mr X with meaningful updates.

Abertawe Bro Morgannwg University Health Board - Complaints handling – Health Case Reference 201504338 – Report issued in March 2016

Ms A complained that a further complaints meeting to review her concerns about the care and treatment provided to her father, Mr A, during his admission to the Princess of Wales Hospital in September 2014 had not been arranged by Abertawe Bro Morgannwg University Health Board (“the Health Board”).

Having considered the information provided on behalf of the complainant, the Ombudsman approached the Health Board on the basis that it appeared that although a number of informal complaints meetings had previously been held to discuss Ms A’s concerns, the Health Board had not yet provided Ms A with a formal complaints response nearly one year later. The Health Board agreed to settle the complaint by providing a formal written response addressing the specific issues of Ms A’s complaint and also by providing Ms A with a redress payment of £250 in recognition of the time and trouble caused due to the delays that had occurred in its complaints handling process.

The Ombudsman concluded that the action which the Health Board said it would take was reasonable to settle the complaint.

Abertawe Bro Morgannwg University Health Board – Complaints Handling – Health Case Reference 201504821 – Report issued in March 2016

Ms A, via her advocate, complained about the length of time that she had been waiting for the Abertawe Bro Morgannwg University Health Board’s (“the Health Board”) complaints response, since April 2015.

Having considered the information provided on behalf of the complainant, the Ombudsman approached the Health Board on the basis that it appeared that there had been an excessive delay in providing a response. The Health Board provided evidence to confirm that it had provided its complaints response in December 2015. In this letter, the Health Board had apologised and explained the reasons for the delay.

In addition, it offered Ms A a redress payment of £250 in recognition of the time and trouble caused to her due to the delays that had occurred in its complaints handling process.

The Ombudsman concluded that the action which the Health Board had taken was reasonable to settle the complaint.

Education

UPHELD

The Admission Authority and Admissions Appeal Panel of All Saints Church in Wales Primary School, Barry - Admissions procedures and appeals

Case references 201501765 and 201502884 - Report issued in March 2016

Mr and Mrs G complained that the Admission Authority and the Admissions Appeal Panel failed to adhere to relevant legislation and to the Welsh Government's Code on School Admission Appeals ("the Code") during the admission appeal process, relating to their application for their son (H) to attend a local voluntary aided primary school.

The investigation found that the Admission Authority failed to adhere to the Code during the arrangement of H's appeal. The investigation also found that the Admission Appeal Panel failed to apply the correct legal test when it considered H's appeal.

The Ombudsman recommended that the Admission Authority:

- a) provide Mr and Mrs G with a written apology and payment of £250 in recognition of the identified failings to follow the Code
- b) offer Mr and Mrs G a fresh appeal panel to consider H's appeal
- c) review the provisions of the Code and produces a written procedure which outlines its admission appeals arrangements
- d) review its arrangements for the training of its panel members and clerks and produces a training programme which is compliant with the Code, and
- e) review its arrangements for the management of its records in relation to admission appeals.

NOT UPHELD

Independent Appeal Panel Penarlag Primary School – Admissions procedures and appeals **Case reference 201503875 – Report issued in January 2016**

Mr and Mrs A complained that the Independent Appeal Panel at Penarlag Primary School ("the Panel") did not administer the appeals process properly as it did not follow the admissions code when hearing multiple appeals and this may have affected the decision not to admit their child to the school.

The Ombudsman found that whilst not all appeals were held on the same day there was no information to suggest that the appeals were not considered independently of each other. This is in accordance with the Welsh Government School Admission Appeal Code and therefore the complaint was not upheld.

Newport City Council – School transport

Case Reference 201502569 – Report issued in March 2016

Mrs D complained that Newport City Council (the Council) did not adequately consult on the proposed introduction of catchment areas for Welsh medium primary schools in its area to take effect from the 2015/16 school year. Mrs D was concerned that she had not been aware of the change when she applied for places for her children. She said that as a result of this, although both of her children were attending the same school, one was eligible for free transport as they had started before the catchment areas were introduced, but the younger was not as they were now considered out-of-catchment.

The Ombudsman found that broadly speaking the consultation was adequate. It had been publicised via a press release and social media, and head teachers were asked to make parents aware of it. There was one failing in that the Chair of Governors of Mrs D's children's school was missed out of an email notifying chairs of the consultation. However, this was not sufficient to undermine the consultation process as a whole. The Ombudsman did not uphold the complaint.

Newport City Council - School transport

Case Reference 201503161 – Report issued in March 2016

Ms E complained that Newport City Council ("the Council") did not adequately consult on the proposed introduction of catchment areas for Welsh medium primary schools in its area to take effect from the 2015/16 school year. Ms E was concerned that she had not been aware of the change when she applied for places for her children. She said that as a result of this, although both of her children were attending the same school, one was eligible for free transport as they had started before the catchment areas were introduced, but the younger was not as they were now considered out-of-catchment.

The Ombudsman found that broadly speaking the consultation was adequate. It had been publicised via a press release and social media, and head teachers were asked to make parents aware of it. There was one failing in that the Chair of Governors of Ms E's children's school was missed out of an email notifying chairs of the consultation. However, this was not sufficient to undermine the consultation process as a whole.

The Ombudsman did not uphold the complaint.

Newport City Council – School Transport

Case Reference 201503238 – Report issued in March 2016

Mrs F complained that Newport City Council ("the Council") did not adequately consult on the proposed introduction of catchment areas for Welsh medium primary schools in its area to take effect from the 2015/16 school year. Mrs F was concerned that she had not been aware of the change when she applied for places for her children. She said that as a result of this, although both of her children were attending the same school, one was eligible for free transport as they had started before the catchment areas were introduced, but the younger was not as they were now considered out-of-catchment.

The Ombudsman found that broadly speaking the consultation was adequate. It had been publicised via a press release and social media, and head teachers were asked to make parents aware of it. The Ombudsman did not uphold the complaint.

Newport City Council – School transport

Case Number: 201504318 – Report issued in March 2016

Mr and Mrs G complained that Newport City Council (“the Council”) did not adequately consult on the proposed introduction of catchment areas for Welsh medium primary schools in its area to take effect from the 2015/16 school year. Mr and Mrs G were concerned that they had not been aware of the change when they applied for places for their children. They said that as a result of this, although both of their children could be attending the same school, one was eligible for free transport as they had started before the catchment areas were introduced, but the younger would not (if their application for a place was successful) as they were now considered out-of-catchment.

The Ombudsman found that broadly speaking the consultation was adequate. It had been publicised via a press release and social media, and head teachers were asked to make parents aware of it. The Ombudsman did not uphold the complaint.

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Neath Port Talbot County Borough Council – School transport

Case reference 201500136 - Report issued in February 2016

Mrs S complained to the Ombudsman that Neath Port Talbot County Borough Council (“the Council”) had treated her child unfairly when it introduced a revised school transport policy. Her child’s primary education had been through the medium of the Welsh language, but the child wanted to pursue secondary education in English. The revised policy of the Council meant that the child would not receive free school transport as the designated school for the child was a Welsh medium school, due to previous preference. Mrs S complained to the Council and there was a delay in the Council responding, although it had granted her child free school transport in the interim.

The Council considered objections to the policy and, after deliberations, suspended it. It approached the Welsh Government for advice on what it saw as conflicting requirements in guidance. The Council agreed that it had left Mrs S in a position of uncertainty and gave a commitment that her child, and other children similarly affected, would receive free school transport until the end of their placement.

The Council agreed to settle the complaint by improving its decision letters and reviewing its policy position in the light of advice received. It also agreed to send an apology to Mrs S and make a payment to her in the sum of £300 for her time and trouble in bringing the complaint.

Cardiff Council – Other

Case reference 201504370 - Report issued in February 2016

Mr A complained about Cardiff Council’s (“the Council”) involvement in matters relating to a governing body of which he was the Chairman. The Ombudsman considered the alleged refusal to provide Mr A with a copy of a review report into the leadership and governance of the governing body and failure to respond to his complaint.

Although the Ombudsman found no evidence that the Council had refused to provide Mr A with the report, it had been provided within 24 hours of a meeting which had not provided him with sufficient time to consider it in advance of the meeting. There was also no evidence that the Council had failed to respond to the complaint, although the Ombudsman considered that the Council's explanation on one aspect of the complaint could have been expanded upon.

The Ombudsman contacted the Council about these matters who agreed to:

- a) apologise to Mr A in recognition of the limited time afforded to him to prepare for the meeting, and
- b) to provide him with a further and better explanation.

Environment and environmental health

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Flintshire County Council – Refuse collection, recycling and waste disposal

Case Reference 201503513 - Report issued in January 2016

Mr P stated in his most recent letter to the Ombudsman that Flintshire County Council (“the Council”) had failed to remove any of the rubbish from outside of his property. Mr P said the Council was failing to do this on a regular basis.

Mr P previously made a complaint to the Ombudsman about this matter and it was agreed with the Council that some sort of monitoring would be put in place to ensure that the rubbish would be collected on a regular basis.

Upon receiving Mr P’s complaint the Ombudsman contacted the Council and asked whether this monitoring was on a permanent basis. The Council responded by saying that it was not a permanent agreement. However, the Council agreed to re-open Mr P’s complaint and alert the Waste Services Manager to the issues and ask that his address is reviewed.

Cardiff Council - Refuse collection, recycling and waste disposal

Case reference 201504991 - Report issued in February 2016

Mr A contacted the Ombudsman to complain that Cardiff Council (“the Council”) had failed on a number of occasions to collect his mother-in-law’s refuse. Mr A had complained to the Council and it had given assurances that the incident would not occur again. However the Council failed to collect the refuse again after issuing an apology.

The Ombudsman contacted the Council and made the following recommendations:

- a) send Mr A a letter of apology explaining what the issues were and why the problems were re-occurring
- b) pay Mr A a time and trouble payment of £25.

Cardiff Council – Refuse collection, recycling and waste management

Case reference 201505462 - Report issued in February 2016

Mr A complained that Cardiff Council (“the Council”) failed to collect his refuse on more than a dozen occasions since May 2015. Mr A had previously complained to the Council about this and was informed that measures had been put in place to prevent this from happening. However, Mr A stated the bins were still not collected on a regular basis.

After discussing the matter with the Council, the Ombudsman asked it to:

- a) write to Mr A with a further apology, explaining what the issues were and what action the Council had taken to try and address the issue

b) make a time and trouble payment of £25 to Mr A.

**Blaenau Gwent County Borough Council - Refuse collection, recycling and waste disposal
Case reference 201505412 - Report issued in February 2016**

In October 2015 Blaenau Gwent County Borough Council's ("the Council") Environmental Services changed recycling and refuse collection points, which prompted Miss H to make a request for assisted collection on behalf of her mother, Mrs H, owing to her physical disability. Mrs H complained that the Council made no response to her initial request, or her subsequent complaint.

The Ombudsman found that the Council had failed to act upon correspondence regarding the complaint and when they had attempted to resolve the matter they approached Mrs H, rather than her daughter who acts on her behalf.

The Ombudsman recommended that the Council:

- a) communicate directly with Miss H
- b) arrange a meeting to discuss and assess Mrs H's requirement for assisted collection
- c) apologise to Miss H at the meeting for the inconvenience and upset caused.

The Council agreed to these recommendations.

Finance and taxation

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Wrexham County Borough Council – Finance and Taxation

Case reference 201504498 – Report issued in January 2016

Mr X complained about the way in which Wrexham County Borough Council (“the Council”) sought to recover council tax relating to a property which he had owned for part of the relevant year. He also complained about the actions of bailiffs who attended his granddaughter’s address (which he had previously given to the Council as a correspondence address for him regarding the property in question).

The Council agreed to:

- a) apologise to Mr X
- b) withdraw the liability order and costs, and allow him to pay the outstanding council tax
- c) apologise to his granddaughter for instructing enforcement at her address, and make a payment of £50 to her for the inconvenience caused.

The Ombudsman considered that the action the Council agreed to take was reasonable and closed his file.

Pembrokeshire County Council – Finance and taxation

Case reference 201505178- Report issued in February 2016

Mr A complained that Pembrokeshire County Council (“the Council”) failed to provide a satisfactory response in relation to council tax issues; delayed the return of a council tax overpayment; and failed to provide a suitable complaints or resolution process.

The Ombudsman was satisfied that there was no maladministration by the Council in relation to its response regarding council tax issues. He did, however, decide that there had been an undue delay in returning a council tax overpayment, and that it had not adhered to its own complaints procedure. He recommended that the Council:

- a) write an apology letter for not following its complaints procedure; and
- b) make an ex-gratia payment of £40 for the delay in returning the tax overpayment.

The Council agreed to the recommendations.

Cardiff Council -Finance and Taxation

Case Reference 201505747 – Report issued in March 2016

Ms C complained that she had made a housing application to Cardiff Council (“the Council”) as she

was overcrowded. Her three daughters (aged 16, 6 and 7) shared a bedroom which affected her eldest daughter's ability to study. She was unhappy with the Council's decision and felt that her application was not afforded sufficient priority to enable her to be housed. The Council's Allocation Scheme was framed so that applicants were placed in Bands which determined priority. The Council acknowledged that Ms C was overcrowded and lacking two bedrooms.

It was not for the Ombudsman to say when an applicant should be housed. As assessed, Ms C's application was correctly placed in the relevant Band. The Allocation Scheme process was duly followed. However, the evidence showed that the Council had assessed Ms C's application in line with one of the two statutory standards for overcrowding (known as the room and space standards). The law required an assessment under both. The Council agreed with the Ombudsman that it would undertake the following actions to resolve the complaint:

- a) to immediately undertake an assessment (including measurements) of Ms C's home in line with the space standard
- b) to amend Ms C's status following the assessment, if appropriate
- c) to apologise in writing to Ms C for its failure to assess fully in the first instance and explain the outcome of the above assessment (providing a copy of that letter to the Ombudsman)
- d) to offer Ms C redress of £100 for her time and trouble in pursuing the complaint with the Ombudsman and for the failings identified.

Powys County Council – Finance and taxation

Case Reference 201502998 – Report issued in March 2016

Ms X complained about the Powys County Council's ("the Council") enforcement of several liability orders for council tax debts. She said that the enforcement notices were confusing; the amounts being enforced were wrong and the charges made by the Council's enforcement agents were excessive and unfair.

On receipt of the complaint, the Ombudsman contacted the Council setting out some immediate concerns. The Council agreed that it was unreasonable for its enforcement agents to call once with several liability orders and to make charges for each one. The Council also found that there were processing errors in respect of Ms X's accounts resulting in the wrong amount of debt being referred to its enforcement agents to collect.

In view of the failings identified, the Council agreed to:

- a) apologise to Ms X
- b) reimburse £394.75 of incorrectly charged fees and waive further enforcement fees of £709.50
- c) review all disputed fee areas in future
- d) review the enforcement notices issued by the enforcement agency, in particular where there are

multiple liability orders, to ensure that debtors are better able to understand which order is being enforced and the payments that have been made

e) address with the Recovery Team the incorrect allocation of repayments resulting in incorrect debt amounts being referred to the enforcement agency to recover

f) write to Ms X outlining the detail of the amendments to her accounts agreed with the Ombudsman and apologise to her for the failings identified

g) address with the Recovery Team the incorrect allocation of repayments resulting in incorrect debt amounts being referred to the enforcement agency to recover

h) write to Ms X outlining the detail of the amendments to her accounts agreed with the Ombudsman and apologise to her for the failings identified.

Cardiff Council - Benefits Administration - Housing Benefit Case Reference 201505395 –Report issued in March 2016

Mr A complained about the action taken by Cardiff Council (“the Council”) to recover an overpayment of housing benefit. He said that debt recovery letters were sent to the wrong postal address on three occasions before the Council contacted his employer to make arrangements for a direct earnings attachment (“DEA”). Mr A explained that the contact with his employer had caused him great embarrassment as he also worked within the payroll section.

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

a) apologise to Mr A for the administrative errors and consequential disclosure of personal, sensitive information to his employer

b) pay Mr A £300 in recognition of the distress caused

c) write to Mr A’s employer to explain that the DEA was sent as a result of administrative errors.

Housing

NOT UPHELD

Isle of Anglesey County Council – Group or block repair/improvement grants (NOT DFGs) Case reference 201408213 – report issued in January 2016

Mr Y received grant assistance from the Isle of Anglesey County Council (“the Council”) under an Empty Homes Grant. Mr Y complained that the Council had inappropriately registered, and dealt with, a land charge against his property at W Street for repayment of those grant monies. The investigation found that the Council registered the land charge as Mr Y had failed to complete the eligible works in accordance with the conditions applicable to his Empty Homes Grant (“EHG”).

The investigation concluded that the Council had appropriately registered the land charge against Mr Y’s property and there was no evidence of maladministration by the Council in the process. Mr Y’s complaint against the Council was therefore not upheld.

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Clwyd Alyn Housing Association Ltd - Repairs and maintenance (inc. dampness/ improvements and alterations e.g. central heating, double glazing)

Case reference 201505386 - Report issued in January 2016

Ms J complained that Clwyd Alyn Housing Association Ltd (“the Housing Association”) had failed to address the heating issues at her home. Ms J explained that she continued to experience issues with the windows at her home, indicating that they are faulty.

The Ombudsman noted that the Housing Association had addressed Ms J’s loft insulation concerns, but concluded that Ms J’s concerns relating to her windows required further consideration. The Housing Association agreed to the recommendations that it should visit Ms J’s home to assess her windows in accordance with its repairs policy.

Ceredigion County Council - Other

Case reference 201505032 - Report issued in February 2016

Ms A contacted the Ombudsman to complain that Ceredigion County Council (“the Council”) had demanded a full repayment of an improvement grant. Ms A said that there was no policy in place; however one was formulated “on the hoof” several years later to facilitate a claim against her. Ms A complained that this claim contributed to the loss of her remaining part in a business. Ms A made a complaint to the Council however the responses received were poor. On receipt of Ms A’s complaint the Ombudsman contacted the Council and asked its position. The Council informed the Ombudsman that the matter had not been fully addressed due to a long-term sickness.

Given this information the Ombudsman asked the Council to:

- a) provide Ms A with a more detailed response that referred to all the issues raised by her

- b) apologise for the delay
- c) offer Ms A a time and trouble payment of £50 for the delay.

Grwp Gwalia Cyf Ltd - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating, double glazing)

Case reference 201505012- Report issued in February 2016

Ms A complained to the Ombudsman following Grwp Gwalia's ("the Housing Association") delay in undertaking agreed works. As a result of the delay Ms A complained that she suffered an inconvenience and was unable to enjoy the comfort of her new home.

The Ombudsman recommended that the Housing Association:

- a) complete the outstanding works by 29 February 2016
- b) pay Ms A the sum of £100 for any inconvenience caused by the delay.

The Housing Association agreed to these recommendations.

Wrexham County Borough Council - Repairs and maintenance (inc dampness/improvements and alterations e.g. central heating/ double glazing)

Case reference 201505632 - Report issued in February 2016

Mr and Mrs M complained to the Ombudsman that they had been experiencing damp and mould in their bedroom following Council maintenance work. They said that they had received very little response to their complaints despite numerous attempts at communication and were dissatisfied with Wrexham County Borough Council's ("the Council") final response letter.

The Ombudsman found that there had been no action to address the current complaint, and no contact made with Mr and Mrs M for three months, and they were still experiencing mould. The Ombudsman recommended that the Council:

- a) contact the complainants directly
- b) arrange an appointment to inspect and survey the mould, and
- c) take appropriate action to address the issue.

Carmarthenshire County Council – Other

Case Reference 201505931 – Report issued in March 2016

Mr A complained to the Ombudsman because Carmarthenshire County Council ("the Council") did not consult him prior to a shared chimney stack being removed. As a consequence the stack was removed without Mr's A knowledge or consent. Mr A also complained that the works were not undertaken in line with building regulations. When Mr A became aware of this he was concerned for the health and safety of his family and turned off the gas appliance. The Council on this occasion agreed to:

- a) pay Mr A £200 in recognition of the distress and inconvenience caused by the lack of involvement in the process to remove the chimney
- b) arrange for a gas engineer to service Mr A's gas fire.

Clwyd Alyn Housing Association Ltd - Repairs and maintenance (inc dampness/ improvements and alterations e.g. central heating. double glazing)

Case Reference 201503831 – Report issued in March 2016

Ms G, a tenant of Clwyd Alyn Housing Association (“the Association”) complained that it had not painted her garden fence, as was promised by an officer she spoke to, following it replacing damaged panels. These were now mismatched and, she felt, unsightly. Ms G also said it was set out in the Association’s Customer Care Charter (“the Charter”) that it would paint/varnish them every five years and the painting of her fence was due. When Ms G complained, the Association said that it had changed its policy on painting. It no longer did so. Its practice was instead to stain the fence’s external face only. Mrs G complained that this was unfair, not what she was told, and was not what the Charter said.

The Ombudsman considered the documentation. When asked, the Association was unable to produce any minutes verifying the agreed change in practice or any notification of it to its tenants. Neither did the Charter itself indicate it. On that basis, the Ombudsman considered that the matter could be settled by the Association agreeing to undertake certain actions to resolve Ms G’s complaint and address the shortcoming identified. The Association agreed to implement all the following recommendations:

- a) to apologise in writing to Ms G for the failures identified and her time and trouble in pursuing her grievances
- b) to offer her the following redress: (i) the sum of £50, and (ii) paint her fence within 2 months
- c) to revise its Charter, providing clarity about its current position on fence painting (and any other changes to its practice on maintenance matters) providing a copy of that document to the Ombudsman on completion, and
- d) to publish details of the revised Charter on your website and in its tenant newsletter.

Flintshire County Council – Applications, allocations, transfer and exchanges

Case Reference 201501721 – Report issued in March 2016

Mr D complained that Flintshire County Council (“the Council”) failed to answer his letters and that it told him it wanted to purchase his home but then changed its mind. Mr D further complained that his house was subject to severe pollution but the Council had failed to take any action to resolve it.

Mr D provided various correspondence passing between him and the Council and the Ombudsman felt that the Council had provided him with a reasonable explanation for its actions. The Ombudsman therefore contacted the Council and asked that it meet with Mr D to discuss his concerns and attempt to resolve them. The Council agreed to contact Mr D to arrange a meeting. The Ombudsman believed that the action which the Council said it would take was reasonable and would resolve this complaint. Accordingly, he considered the matter to be settled. However, it is also noted that Mr D had not submitted a complaint to the Council and therefore was advised that if he remained dissatisfied with the explanations provided it would be open to him to raise a formal complaint with the Council for investigation in line with its complaints procedure.

Planning

NOT UPHELD

Gwynedd Council - Handling of planning application (other)

Case reference 201501468 – Report issued in January 2016

Mr X complained about the grant of planning permission for the change of use of land to extend an existing holiday park (“the holiday park”) near his parent’s property in order to relocate 12 static holiday caravans. He said that Gwynedd Council (“the Council”) had failed to notify his parents of the application and had failed to protect trees near the site and the habitat of several species.

The Ombudsman found that the Council had complied with notification requirements for the application, and had taken account of the responses it received from environmental consultees. It was entitled to reach the conclusions it did and there was no evidence of maladministration. He did not uphold the complaint.

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

Case reference 201409301 – Report issued in January 2016

Mrs D complained about the manner in which Carmarthenshire County Council (“the Council”) had dealt with a retrospective planning application. She stated that enforcement action had been delayed and that the Council had not taken account of her objections to the application.

The Ombudsman found that whilst there was a time between the knowledge of the existence of the building in question, and the eventual enforcement (in terms of a retrospective planning application), it was not unreasonable for the Council to focus on the enforcement of the business issue at the site in the first instance. He also found that the manner in which the Council dealt with the retrospective planning application and Mrs D’s objections to it was reasonable. He did not uphold the complaint.

The Ombudsman did note the Council’s new practice of not writing officer reports for delegated decisions. Whilst there is no obligation for the Council to do so, the Ombudsman did raise some concerns that the Council needed to ensure that it gave adequate explanations and reasons for its decisions. The Council agreed to look at whether improvements could be made to its processes on this issue.

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Ceredigion County Council - Unauthorised development - calls for enforcement action etc.

Case reference 201504844 - Report issued in February 2016

Mr A complained that he had not received a response to his complaint under Stage 2 of Ceredigion County Council’s (“the Council”) complaints process over a three month period.

The Ombudsman found that delays had occurred in providing Mr A with a response. This was due to the complexity of the matter and the Council’s decision to obtain legal advice. However, the Council had not provided Mr A with regular updates in accordance with its complaints policy which had resulted in Mr A

contacting the Ombudsman.

The Ombudsman contacted the Council about the matter who provided Mr A with a proper update. It also agreed to apologise to Mr A for the failure to update him and offer a payment of £75 in recognition of the time and trouble caused to him due to this failure.

Pembrokeshire Coast National Park Authority - Unauthorised development - calls for enforcement action etc. Case Reference 201409768 – Report issued in February 2016

Mr A said that he and his wife owned a caravan in a Holiday Complex ("the Complex"), which adjoins a car park ("the Car Park"). He reported that contractors, working on behalf of a public body ("the Body"), had been setting up temporary depots in the Car Park, during the winter, when the Complex was closed. He indicated that, recently, these depots had been getting bigger and staying in the Car Park for longer and after the Complex had re-opened for the new season. He said that he and his wife had experienced significant disruption because of this. He also noted that he had relayed his concerns, about these depots, to Pembrokeshire Coast National Park Authority ("the Authority"). He suggested that it should have taken enforcement action, against the Body, as a result. He complained about the Authority's failure to do this.

The Ombudsman considered that the Authority had not managed the depot situation properly. He decided that it would be appropriate to try settling Mr A's complaint. The Authority subsequently agreed to:

- a) write to Mr A to apologise for the enforcement- related failings identified
- b) pay Mr A £100 in recognition of the fact that some of the disruption, which he and his wife had experienced, might have been avoided if the failings cited had not occurred
- c) pay Mr A £250 in recognition of the time and trouble that he had taken in pursuing his enforcement-related complaint
- d) review its current arrangements for recording and monitoring enforcement concerns and related activity
- e) prepare an action plan following its recording and monitoring review.
- f) confirm, in writing to the Ombudsman, that it would complete the tasks identified in the action plan cited within three months of its preparation
- g) arrange for its Planning and Planning Enforcement Officers to receive training about permitted development rights.

The Ombudsman considered that the action, which the Authority had agreed to take, was reasonable. Accordingly, he regarded Mr A's complaint as settled.

Rhondda Cynon Taf County Borough Council - Other planning matters

Case Reference 201505787 – Report issued in March 2016

In April 2015, Ms X complained to Rhondda Cynon Taf County Borough Council (“the Council”) about the sale of a piece of land opposite a property she owned. Ms X complained to the Ombudsman that the Council had failed to respond to her letter of complaint.

On receipt of the complaint, the Ombudsman contacted the Council to discuss Ms X’s concerns. The Council agreed to resolve the complaint on the following basis:

- a) to provide a detailed response to the concerns which Ms X raised with the Council
- b) to apologise for the significant delay in respect of providing the response, and
- c) to make an offer of £250 by way of apology in recognition of the delay in responding.

Merthyr Tydfil County Borough Council - Rights of way and public footpaths

Case Reference 201503334 – Report issued in March 2016

Mr and Mrs A complained about a number of matters relating to a public footpath that passes along the route of privately owned track which also serves as the access to their property. In particular, Mr and Mrs A complained that Merthyr Tydfil County Borough Council (“the Council”) failed to take enforcement action to ensure the removal of an unauthorised field gate obstructing the footpath. The Ombudsman found that, although the decision to take enforcement action was a discretionary matter for the Council, it had not taken the decision in a proper manner.

In settlement of the complaint, the Council agreed to consider the enforcement decision again and to provide a copy of the new decision record to Mr & Mrs A.

Social services - Adult

UPHELD

Powys County Council – Services for older people

Case reference 201301955 – Report issued in January 2016

Mr A was dissatisfied with Powys County Council's ("the Council") Protection of Vulnerable Adults ("POVA") investigation into the care and treatment that his late mother, Mrs A, received while a resident at a care home.

The Ombudsman found significant shortcomings in the way that the Council managed and conducted the POVA process. However, as the Council had reorganised the way that it dealt with POVA matters since Mr A's complaint, the Ombudsman's recommendations reflected this.

The Ombudsman recommended that:

- a) the Council's Chief Executive apologise to Mr A for the failings
- b) a payment was made to Mr A of £750 in recognition of the distress and inconvenience caused to him as a result of the shortcomings
- c) the Council's Chief Executive confirm to Mr A in writing the measures the Council had taken to date to prevent a re-occurrence of the failings identified.

The Council agreed to implement the recommendations.

Betsi Cadwaladr University Health Board - Services for vulnerable adults (e.g. with learning difficulties, or with mental health issues)

Case reference 201505025 - Report issued in February 2016

Mr X complained that he had been advised by Betsi Cadwaladr University Health Board ("the Health Board") that its decision regarding his late mother's continuing health care application was relayed to her social worker but that he had not yet received details of that decision.

On receipt of this complaint the Ombudsman contacted both the Health Board and the appropriate Council to discuss these concerns. It was apparent that the Health Board had failed to provide the details of the outcome to both Mr X and the social worker. The Health Board therefore agreed to undertake the following actions:

- a) write to Mr X with an apology for its failings
- b) provide a formal explanation of its outcome together with any course of action which may be available to him
- c) offer financial redress for the time and trouble taken in making this complaint.

NOT UPHELD

Care and Sociak Services Inspectorate Wales (CSSIW) - Other Case Reference 201503480- Report issued in February 2016

Mr A complained about the way that CSSIW carried out its functions. This followed a complaint in which he had raised specific and general concerns about how a local authority was applying and interpreting the Welsh Government's Charges for Residential Accommodation guidance ("Crag").

The Ombudsman considered the action that CSSIW had told Mr A it would take, namely to raise the issue of how the local authority was applying Crag at a meeting with senior local authority officers, was reasonable. Mr A's complaint was not upheld.

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Caerphilly County Borough Council - Services for vulnerable adults (e.g. with learning difficulties, or with mental health issues)

Case reference 201506381 – Report issued in March 2016

Mr A complained to the Ombudsman that Caerphilly County Borough Council ("the Council") had failed to arrange for him to have a needs assessment and because there was no assessment, the support that he was receiving was inadequate. Mr A was also unhappy that he did not have support from a suitable advocate to assist him obtain the care and support he felt he needed.

The Council explained that once it had undertaken a capacity assessment (which had been arranged to take place within a month). It indicated that an advocate had been identified to assist Mr A through this process.

Following discussions with the Council it confirmed that it would:

- a) ensure Mr A would carry out a capacity assessment on 12 April 2016
- b) complete an assessment of Mr A's needs within 28 days of the capacity assessment
- c) arrange for Mr A to have an advocate to support him.

Social services - children

UPHELD

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

Case reference 201501491 - Report issued in March 2016

Mr and Mrs R complained to the Ombudsman about aspects of an independent investigation the Council arranged under Stage 2 of its Social Services complaints procedure. They also complained about the Council's response to the investigation including the action plan it created to address the Stage 2 Investigation report's recommendations. They were also concerned with the Council's correspondence with them following the issuing of the report.

The Ombudsman did not find that the Stage 2 Investigation was flawed and did not uphold this aspect of the complaint. However, he considered the Council had failed to engage adequately with Mr and Mrs R when preparing elements of its action plan, had not corrected inaccurate records it held soon enough and had misrepresented comments within the Stage 2 report. These elements of the complaint were upheld whilst aspects of the complaint about the implementation of the recommendation by the Council were not.

The Ombudsman recommended that the Council:

- a) provide Mr and Mrs R with a fulsome apology and redress of £250
- b) correct the records it held on Mr and Mrs R, and
- c) amend its procedures for responding to certain types of complaints.

Flintshire County Council - Other

Case Reference 201501020 – Report issued in March 2016

Ms A is a special guardian for a child. She complained that Flintshire County Council ("the Council"):

- 1) did not increase her special guardianship allowance ("SGA") in line with increases to its fostering allowance until she brought this fact to its attention. She said that there was delay in making the back payments and that the Council did not apologise for its errors, and
- 2) refused to pay an additional element to cover expenses relating to birthdays/holidays/etc which she would have been entitled to under the fostering allowance arrangements.

The Ombudsman upheld the complaint about the delay in applying annual increases to Ms A's SGA as this should have happened as a matter of course, notwithstanding the fact Ms A had omitted to update the Council of a change of address on at least one occasion.

The Council agreed to:

- a) apologise to Ms A
- b) pay Ms A £250 to recognise the time and trouble she had been put to, and
- c) to review the records of other recipients of SGA in its area to ensure they had received the annual increases.

The Ombudsman did not uphold the complaint about the payment of the additional allowance for birthdays etc. as guidance issued by the Welsh Government (unlike the equivalent guidance in England) does not require that local authorities use the core fostering allowance as a benchmark for setting the level of SGA.

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Rhondda Cynon Taf County Borough Council - Social Care Assessment Case Reference 201506335 – Report issued in March 2016

Ms X complained that after Social Services returned her children to her care she noticed that they had both sustained a number of injuries and illnesses. Ms X complained that when she reported these injuries and illnesses to the Social Worker she did not have any concerns about the welfare of the children.

After carefully considering this complaint, it was apparent that Rhondda Cynon Taf County Borough Council ("the Council") had not addressed all the concerns Ms X raised in her original complaint to it. The Ombudsman therefore asked the Council to reconsider the complaint and provide a more substantive response which it agreed to do.

Various - other

QUICK FIXES AND VOLUNTARY SETTLEMENTS

Newport City Council - Licensing - liquor & public entertainment

Case reference 201505436- Report issued in February 2016

Mr W made a complaint to the Ombudsman in October 2015 who referred it to Newport City Council ("the Council") for it to consider under its complaint procedure. Mr W contacted the Ombudsman for the second time stating that he had not received any correspondence since the referral, or a response to his complaint.

The Ombudsman contacted the Council on behalf of Mr W and it confirmed that it had completed a review of Mr W complaint and a draft response had been produced. The letter would be sent to Mr A once the legal team had reviewed it. The Ombudsman therefore considered the matter to be resolved.

Conwy County Borough Council – Tourism - other

Case Reference 201505996 – Report issued in March 2016

Mr K, whose company operated a website, complained that Conwy County Borough Council ("the Council") had granted funding to a local group who developed a website containing information similar to the one he ran. Consequently, Mr K complained that the group was able to facilitate advertisements at a lower cost, so securing them an unfair advantage, which resulted in his company losing advertising business. Mr K raised the issue and held meetings with the Council over many months citing its actions as a breach of the Competition Act 1998. He then formally complained. The Council responded to the complaint some five months later. It said that it had sourced advice from its legal department which said there was no breach. It said it was a question of interpretation. The website entries were listings and not advertisements.

The Ombudsman said that it was not unreasonable for the Council to rely on legal advice. He would not investigate the funding issue as it was not his role to be the arbiter on a question of legal interpretation. Such matters were for the courts.

The Ombudsman, however, did consider that the Council had unreasonably delayed in responding to Mr K's complaint. It was aware of the issues for some time so could have procured internal legal advice much sooner. Its complaints policy required a complaint response within 20 working days.

The Ombudsman recommended, and the Council agreed to, the following as a resolution:

- a) an apology in writing to Mr K for the complaint handling delay
- b) an offer of financial redress of £50 for that delay.

More information

Full reports can be found on our website: www.ombudsman-wales.org.uk. If you cannot find the report you want, you can request a copy by emailing ask@ombudsman-wales.org.uk.

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

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