

# The Ombudsman's Casebook

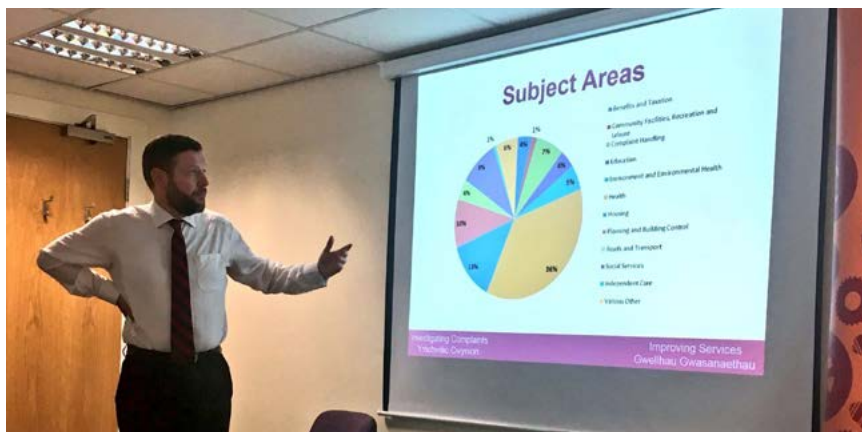
Issue 25 July 2016

## News

### Embracing Complaints

The Ombudsman was the principal speaker at two Wales Audit Office seminar events in North and South Wales, attended by more than 90 people.

He spoke about trends in public service complaints, governance, empowering staff to resolve complaints and the importance of organisational culture in handling complaints.



### Sounding Board Launched

June saw the inaugural meeting of our Service User Sounding Board which was set up to gather feedback on our services and processes as well as facilitate two-way communication with third sector stakeholders.

Attendees included representatives from Age Cymru, Citizens Advice and Shelter. The group gave useful feedback on a variety of topics including improving transparency in our equality data capture around diversity and the role of advocates in supporting our customers.



### Welsh NHS Complaints Up Four Per Cent, New Ombudsman Figures Reveal

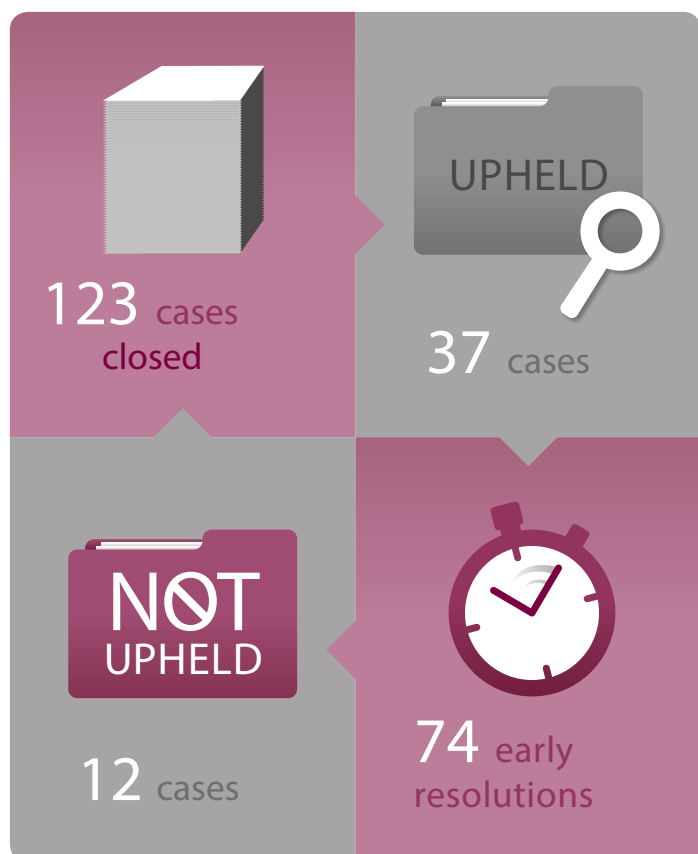
Complaints made against Welsh NHS bodies to the Public Services Ombudsman for Wales have risen by four per cent over the past year, according to new figures

The Ombudsman, Nick Bennett, called for stronger leadership to “turn the curve” of complaints and said new Assembly legislation for his office was needed to improve public services in Wales. The 2015/16 annual report can be accessed [here](#).

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## Casebook in numbers



This infographic illustrates the cases closed between April and June 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 early resolutions category also includes voluntary settlements.

## Health

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

### Hywel Dda University Health Board – other Case Reference 201600223- Report issued in May 2016

Ms A had complained to Hywel Dda University Health Board (“the Health Board”) in June 2014 concerning her son’s ophthalmic care, but had not received a response to the complaint. She complained to the Ombudsman in January 2016, asking him to investigate the Health Board’s handling of her complaint and secure a response. In accordance with his powers, the Ombudsman resolved the complaint (as an alternative to investigation) on the basis of the Health Board’s agreement to a number of actions, including an apology, financial redress for the complaint handling delays, and confirmation as to when the written response would be sent. These actions were to be completed by 15 March 2016.

Being dissatisfied that the Health Board had not complied with the earlier recommendations, the Ombudsman invoked his powers to issue a special report. This was critical of the Health Board’s actions in the meantime and its failure to implement the recommendations it had previously agreed to. Therefore, the Ombudsman made further recommendations:

- (a) issue the complaint response to Ms A without further delay
- (b) issue an additional written apology to her for the continued delay
- (c) offer Ms A further financial redress of £100 for that delay
- (d) provide copies of the letters to the Ombudsman.
- (e) the Chief Executive should personally respond to the Ombudsman after undertaking a review of the resources within the Concerns Team and its capacity to deal with the number of complaints received in a timely way.

## OTHER REPORTS - UPHELD

### Cardiff and Vale University Health Board - Clinical treatment outside hospital

Case reference 201502118 – Report issued in April 2016

Ms D complained to the Ombudsman that the Cardiff and Vale University Local Health Board (“the Health Board”) Community Mental Health Teams had failed to share her care and treatment plan (CTP) with her for her input and agreement. She was also concerned that appointments with her Community Mental Health Nurse had been cancelled unreasonably at short notice and with no explanation and that communication with her had been poor.

The Ombudsman found that Ms D’s CTP had been completed without Ms D’s involvement and that this was unreasonable. Whilst the impact of this failing on the care provided to Ms D seems to have been minimal, it could have caused her distress and could impact on her willingness to engage with the service in future. The Ombudsman upheld this aspect of the complaint. The Ombudsman found that other elements of care provided to Ms D were reasonable and therefore these aspects were not upheld.

The Ombudsman recommended that the Health Board:

- a) apologise to Ms D
- b) provide her with redress of £300, and
- c) undertake and expand its regime of casework audits, shares the outcome of these with him and arrange for staff to receive training where indicated.

### Cwm Taf University Health Board - Clinical treatment in hospital

Case reference 201502860 – Report issued in April 2016

Mr X complained about the care his late mother (Mrs A) received in Ysbyty Cwm Rhondda over a period of some months. He said that she did not receive appropriate treatment because the deterioration in her condition was not recognised, and there was a delay in calling an ambulance for her to be transferred to the Royal Glamorgan Hospital. He also said that there had been no discussion with the family about a possible DNAR order, despite the records documenting that this should be done.

The Ombudsman partly upheld the complaint. He found that Mrs A had been seriously ill and had received appropriate treatment for her condition, although her family had not been made aware of how ill she was. There should have been a DNAR order in place; if there had been, Mrs A would have received appropriate end of life care, and would not have been transferred to the Royal Glamorgan Hospital.

However, the Ombudsman found that, sadly, the outcome would have been the same. He recommended the Health Board:

- a) apologise to Mr X

- b) pay him £750 in recognition of the distress cause, and
- c) review its criteria for ensuring patients are suitable for transfer to community hospitals, and that the case be discussed at the Consultant's annual appraisal.

## Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

### Case reference 201501497 - Report issued in April 2016

Mr A complained that his late mother, Mrs B, was incorrectly told that she had pancreatic cancer, causing her to "give up" and her health to deteriorate. The Ombudsman found that the record which the doctor made of the conversation showed that he warned that Mrs B might have cancer. It was reasonable for Mrs B to be told this, but she should have been told at the earliest opportunity that this was not the case. There was a delay in the outcome of the multi-disciplinary meeting being made available to clinicians, and there was no record of the family being told that Mrs B did not have cancer.

The Ombudsman found that there were failings in communication with Mrs B and her family, but Mrs B's belief that she had, or at least might have, cancer did not contribute to her deterioration. Mrs B was very unwell, and there was evidence she was depressed before this. The Ombudsman partly upheld the complaint.

The Ombudsman recommended that the Health Board:

- a) apologise to Mr A
- b) review its procedures for communicating the outcome of meetings to clinicians, and
- c) remind staff of the importance of communication with patients and their families, and of the recording of discussions.

## Betsi Cadwaladr University Health Board - Clinical treatment in hospital

### Case reference 201502424 - Report issued in April 2016

Ms B complained about the post-operative nursing care her late father Mr B received while an inpatient at Glan Clwyd Hospital for a broken femur. Ms B stated that her father's leg had become trapped in a bed rail and he had suffered injury to both calves. Ms B also complained about Betsi Cadwaladr University Health Board's ("the Health Board") poor complaint handling which included delays in responding to her complaint.

The Ombudsman considered that Mr B's overall nursing care was reasonable and tailored to his needs. However, he said that there should have been an assessment of Mr B's risk of developing pressure ulcers with any existing wound documented and a care plan put in place to minimise any risk identified. Administratively, the Ombudsman was critical of the poor nursing records and the loss of part of Mr B's nursing records which meant that Ms B was denied an opportunity to have an independent review of her complaint by the Ombudsman. The Ombudsman was also critical of the excessive delays in dealing with Ms B's complaint. He upheld these aspects of Ms B's complaint. The Ombudsman recommended that the Health Board:

- a) apologise to Ms B for the failings identified by the investigation
- b) pay her the sum of £500 for the loss of records and £250 for the delay in complaint handling, and
- c) remind staff about their professional obligation to keep proper records in accordance with the Nursing and Midwifery guidance.

## **Cwm Taf University Health Board – Clinical treatment in hospital**

### **Case reference 201409047 – Report issued in April 2016**

Mr J complained about the medical and nursing care and treatment provided to his late mother, Mrs J, during her admission to the Royal Glamorgan Hospital in February 2013. He also complained about communication with the family, raising particular concerns about communication and discussion regarding a Do Not Attempt Cardiopulmonary Resuscitation (“DNACPR”) decision. He complained that Mrs J was not given adequate fluids and, again, about poor communication about these issues. He was concerned about the standard of record keeping, pointing to inaccuracies in the National Early Warning Score (“NEWS”) charts and the fact that nursing records went missing following his mother’s death.

Following investigation, the Ombudsman concluded that clinical treatment was reasonable, but that there were shortcomings in communication with the family and a failure to involve the family in important decisions. There were also some failings in the level of nursing care provided and in record keeping. Finally, Cwm Taf University Health Board (“the Health Board”) had not dealt appropriately with Mr J’s complaint.

The Ombudsman made a number of recommendations to address these shortcomings. These included:

- a) highlighting the importance of proper discussion with the family prior to any DNACPR decisions at departmental meetings
- b) involving family members in palliative care discussions
- c) ensuring appropriate observations and recording of scores
- d) reminding staff of the need to comply with NMC guidance in record keeping and to handle complaints in accordance with the required timescales, and
- e) that the Health Board apologise to Mr J and make a payment to him of £600 in recognition of the poor complaints handling and the distress caused by the communication and record keeping failings in this case.

## **Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital**

### **Case reference 201502878 – Report issued in April 2016**

Miss M complained about the care and treatment her late sister, Miss B, received at Singleton Hospital. Miss M had concerns about how her late sister’s cancer care had been managed, these included problems with provision of medication, diagnosis, record keeping and basic nursing care.

Advice was taken from the Ombudsman's Professional Advisers for oncology and nursing. The Ombudsman was satisfied that the medical care had been satisfactory but found that there were failings in relation to Miss B being discharged without some medication, and in nursing care, record keeping and communication with Miss M. The complaint was partly upheld.

Although Abertawe Bro Morgannwg University Health Board had already taken a number of measures to improve care on the ward in question, it accepted some further recommendations from the Ombudsman in relation to the completion of nursing assessments, management of medication, and documentation of patients' falls risk.

### Hywel Dda University Health Board - Other

Case reference 201502092 – Report issued in April 2016

Ms A complained on behalf of Mr C, who had complex health needs, severe communication difficulties and learning disabilities, about a hospital discharge. She felt that the decision to discharge him was related to the decision not to fund one of his carers to stay with him. Ms A also complained about the delay in dealing with the complaint.

The Ombudsman found that whilst the decision to discharge Mr C was not clinically unreasonable, it should have been considered in the context of Mr C's overall needs. He found that the decision not to fund one of his carers to stay with him did not take sufficient account of Mr C's particular needs and did not appear to have been in his best interests. He upheld this complaint. The complaint about the delay in dealing with Ms A's complaint was also upheld.

The Ombudsman recommended that the Health Board:

- a) apologise to Ms A for the poor complaints handling
- b) offer her £400 redress in recognition of this and offer to meet with her to discuss the action it has taken to improve its care of patients with learning disabilities, and
- c) review its arrangements for authorising requests for additional patient funding for patients with learning disabilities.

### Powys Teaching Health Board - Continuing care

Case reference 201408376 – Report issued in April 2016

Mrs X complained about the way in which Powys Teaching Health Board ("the Health Board") managed her retrospective claim for NHS Funded Continuing Care ("NHSFCC").

The investigation found that the Independent Review Panel ("IRP") had failed to inform Mrs X of the process, in writing, before a negotiation meeting took place. The Ombudsman took the view that doing so would have enabled Mrs X to have made an informed decision about pursuing her claim. Secondly, despite the obvious relevance of the negotiation meeting notes, the IRP did not consider them before reaching its eligibility decision. The Ombudsman partly upheld the complaint. He recommended that the Health Board:

- a) apologise to Mrs X
- b) prepare an action plan detailing how it will address the failings identified, and
- c) arrange for a fresh IRP to review the claim taking into account the negotiation meeting notes and the comments on the Clinical Adviser's revised eligibility recommendation during this review.

## Cardiff and Vale University Health Board – Clinical treatment outside hospital

### Case reference 201503114 – Report issued in May 2016

Mrs Y complained about the care and treatment that her husband (Mr Y) received following surgery to remove a tumour. Mrs Y said that a Doctor at an out-patient appointment in February 2015 had failed to take seriously her husband's comments and a scan was not organised in line with what they had been told to expect. She also complained that there had been a further delay/mix up in the arrangements for Mr Y to have a scan following the identification of a possible return of a tumour in May 2015. Mrs Y also expressed concern about Cardiff and Vale University Health Board's ("the Health Board") response to her complaint.

Having taken account of clinical advice, the Ombudsman found that the judgement made by the Doctor at the appointment in February was not wholly unreasonable and he did not uphold this aspect. Due to limitations in record keeping, the Ombudsman could not identify what exactly Mr and Mrs Y had been told previously to expect in terms of a treatment plan.

The Ombudsman upheld the complaint about the problems with the scan being organised in May and recognised that this caused additional stress for the family.

The Ombudsman partly upheld the concern about the Health Board's complaint response.

The Ombudsman recommended that the Health Board:

- a) apologise to Mrs Y, and
- b) provide financial redress of £1,500 for the distress caused and that it puts in place a more effective system of communication for managing scan requests.

## Cwm Taf University Health Board - Clinical treatment in hospital

### Case reference 201500534 - Report issued in May 2016

Mrs T complained about the treatment that Cwm Taf University Health Board ("the Health Board") gave her daughter, S, at the Royal Glamorgan Hospital ("the Hospital"), following a road traffic accident. S sustained a head injury as a result of this accident. Mrs T said that the Doctor, who had seen S, had not completed a full physical examination of her. She also reported that he had not arranged for a scan or X-rays of S's head to be taken before discharging her. She suggested that S should have had treatment for concussion at the Hospital.



The Ombudsman found that the Doctor's physical examination of S, during her general trauma assessment, was deficient because he had not demonstrated that he had undressed her and completed a thorough and systematic survey of her entire body. He also considered that the Doctor's assessment of S's head injury was inadequate because he had not demonstrated that he had considered whether she had amnesia or arranged for her to be observed, for a minimum of four hours, before discharging her. He was satisfied with the Health Board's management of the concussion issue.

The Ombudsman upheld Mrs T's complaint because he concluded that the Doctor had not assessed S properly. He recommended that the Health Board:

- a) apologise to Mrs T
- b) pay her a nominal sum of £200, and
- c) provide training for relevant staff members and share his report with them.

The Health Board agreed to implement these recommendations.

**Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital**  
**Case reference 201501077 - Report issued in May 2016**

Mr S complained about the care and treatment that his late father-in-law, Mr F, received following his admission to the Princess of Wales Hospital ("the Hospital") in January 2014 with a history of recurrent falls, lethargy, epileptic seizures, poor appetite, weight loss and bouts of confusion. Mr S complained that clinicians failed to ensure that Mr F received adequate fluids and food and failed to adequately manage and record Mr F's confused behaviour.

Mr S also complained that, despite Mr F's confused and vulnerable condition, he was taken to the Radiology Department for an X-ray by a hospital porter without a nurse escort. On arriving at the Radiology Department, the hospital porter briefly left Mr F unattended in his bed in the corridor in order to report his arrival to the Radiologist. During this brief interim, Mr F suffered a cardiac arrest. Mr F was resuscitated and transferred to intensive care, but, sadly, passed away a few days later.

The Ombudsman did not uphold Mr S's complaint that Mr F did not receive adequate fluids and food but upheld all of Mr S's other complaints. The Ombudsman concluded that, in accordance with Abertawe Bro Morgannwg University Health Board's ("the Health Board") Patient Escort Policy, Mr F should have been accompanied by a nurse (in addition to the porter). Whilst Mr F's cardiac arrest would not have been prevented by the presence of a nurse escort, it was fortuitous that Mr F's sudden deterioration was swiftly detected. The Ombudsman considered it an injustice to Mr F that he experienced the onset of a cardiac arrest while alone and without any reassurance that this had been noticed and that help would be forthcoming.

The Ombudsman recommended that the Health Board:

- a) provide Mr S with a fulsome apology

- b) make a payment to him in the sum of £500 in recognition of the identified failings and the inconvenience of pursuing a complaint about a matter which the Health Board might have acknowledged as a clear-cut service-failure earlier on in the process, and
- c) ensure that clinicians are reminded of the provisions of the Escort Policy and of the requirement to assess, record and monitor the mental state/mental capacity of patients.

## **Betsi Cadwaladr University Health Board - Clinical treatment in hospital** **Case reference 201401702 - Report issued in May 2016**

Ms A complained about the standard of care provided to her late father in 2009. The complaint process had been ongoing since that time and the nature and length of this process formed a large part of the complaint. The Ombudsman found that Betsi Cadwaladr University Health Board's ("the Health Board") initial investigation of the complaint was poor. This had resulted in later delays and a lack of trust in the process. The Health Board subsequently investigated the complaint in 2012 and identified shortcomings in nursing care. Independent clinical advice obtained in 2013 found no failings in medical treatment.

The Ombudsman upheld the complaint about the handling of Ms A's complaint in that:

- a) there were shortcomings in the complaints investigation and process
- b) the identified shortcomings in nursing care had not been discussed with relevant nursing staff at any point
- c) there were ongoing concerns about the quality of nursing care documentation and recording
- d) there was no evidence of any learning from the complaint.

The Ombudsman made a number of recommendations. These included:

- a) arrangements for effective complaints handling in line with its obligations under PTR
- b) ensuring both localised and organisational learning from concerns and serious incidents
- c) clarification that the Health Board's system for auditing the standard of clinical recording was robust
- d) clarification about the availability of certain gastroenterology procedures (in particular ERCP) across the Health Board on an elective and emergency basis.

## **Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital** **Case Reference 201500537 – Report issued in May 2016**

Mrs F complained on behalf of her husband, Mr F, about his treatment and care at Morriston Hospital ("the Hospital"). Mrs F was most concerned about the waiting time for Mr F's cardiac surgery. By the time of his surgery, Mr F had been admitted to Morriston Hospital as an emergency on two occasions

and his condition had deteriorated. He experienced significant post-operative complications of cardiac tamponade, breathing difficulties and bilateral vocal cord paralysis, prolonging his recovery.

Mrs F felt that earlier surgery was indicated at the time of the emergency admissions and that her husband would have "fared better" post-operatively had his surgery been brought forward. Mrs F also complained about poor communication and delays in relation to Mr F's later transfer to another hospital for specialist care.

The Ombudsman found that, given his changing symptoms, Mr F was not prioritised for surgery on the basis of his clinical need as he should have been. There were missed opportunities at a clinic appointment in March 2013, and during emergency admissions in April and May 2013, to expedite a surgical referral. The weeks of waiting between tests and appointments resulted in an excessive delay for a patient who was at high risk of a cardiac event.

By failing to take appropriate steps to prioritise his treatment, the Health Board also failed to minimise the risk of complications occurring. However, it was not possible to say definitively that the delay was directly causative of the complications Mr F went on to experience and the procedure itself appeared to have been successful in restoring his heart function to near normal. The investigation also identified some poor and inappropriate communication with Mr and Mrs F whilst he waited for a transfer to another hospital.

The Ombudsman recommended that the Health Board should:

- (a) apologise to Mr F and Mrs F for the failings identified in the report
- (b) make a payment to Mr F of £1000 in recognition of his overly delayed surgery and the unnecessary suffering and uncertainty caused to him and his family as a consequence
- (c) ask the Cardiology Consultant to reflect on this case and identify any supervision needs in relation to the care of patients who present as an emergency with changing symptoms and who are awaiting treatment
- (d) carry out a survey among the Cardiology clinicians to identify any barriers to obtaining urgent inpatient investigations
- (e) at a documented meeting, remind the relevant nursing staff of the requirements of the NHS complaints procedure.

## **Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital** **Case Reference 201500835 - Report issued in May 2016**

Mrs C complained about the care and treatment provided to her son, D. In particular, she was concerned that despite deterioration in his health, a Consultant Paediatric Neurologist ("the Consultant") ignored her reports of pain and deterioration, failed to monitor and manage a clinical trial of Gabapentin recommended by a specialist hospital and did not arrange for a further pain referral despite it being requested.

Mrs C also complained that a meeting in March 2015 went ahead without her and that the Consultant had written incorrect and false information in a consultation letter about an appointment in April 2015. The Ombudsman found that the Consultant had taken Mrs C's concerns into account and carried out appropriate examinations. He also concluded that the trial of Gabapentin was carried out as intended.

In terms of a further pain referral, he found that there was no clinical indication for this and in any event, the Consultant had written to the specialist hospital for further advice. He found that whilst there were two minor inaccuracies in the clinic letter, these did not compromise D's care and were later addressed in the same letter. These complaints were not upheld.

He partially upheld the complaint relating to the March 2015 meeting. This was to the limited extent that, as a matter of good administration, when Mrs C left a message asking someone from the Health Board to contact her to discuss the meeting arrangements, there is no record that her call was returned or that confirmation was provided that the meeting was going ahead.

### Hywel Dda University Health Board and a GP in the Hywel Dda University Health Board area – other Case Reference 201501039 & 201501040 – Report issued in June 2016

Mr Y was terminally ill with heart failure. Miss X complained that both Hywel Dda University Health Board's ("the Health Board") District Nursing Services and the GPs at the Practice failed to put in place specific and appropriate palliative care arrangements for Mr Y, which resulted in him suffering a painful, distressing and undignified death.

The investigation found that there was service failure by both the Health Board and the Practice in the lack of planned provision of palliative care and support for Mr Y, lack of leadership in Mr Y's care, a lack of any robust system to monitor Mr Y's changing needs, and a failure overall to provide a holistic approach to his care. The service failures led to an injustice to Mr Y, and Miss X, as it caused unnecessary psychological distress for them both on the day Mr Y died, and Miss X remains concerned about whether the outcome may have been different had the appropriate palliative care, monitoring and pain relief been in place for Mr Y. Whilst Mr Y's eventual outcome may not have been different, his final days are likely to have been more peaceful and dignified which could have lessened the traumatic experience suffered by both Miss X and Mr Y on the day he died.

Miss X's complaint was upheld against both the Health Board, and the Practice. The Ombudsman recommended both the Health Board and the Practice should apologise to Miss X for the failings identified by the investigation, and each should pay her the sum of £1,000 and £2,000 respectively, in recognition of the distress and uncertainties caused by the shortcomings identified. In addition, appropriate recommendations were made to address the identified shortcomings in Mr Y's care.

### A GP Practice in the Cwm Taf University Health Board area –Clinical treatment in hospital Case Reference 201501651 – Report issued in June 2016

Miss W complained that the Practice had failed to recognise, diagnose and treat a skin infection to her lower left leg at three consultations in March 2015. Miss W considered that the Practice's failure to treat the infection caused it to develop into a serious ulceration resulting in a permanent scar.

The Ombudsman concluded that the first consultation was within acceptable clinical practice; however, the second and third consultations were not. The shortcomings identified amounted to service failure by

the Practice, which led to an injustice to Miss W by the unnecessary delay in the identification and start of her treatment (by seven days). Miss W's complaint was upheld to this extent.

The Ombudsman recommended that the Practice apologise and pay the sum of £750 to Miss W in recognition of the distress and uncertainties caused by the shortcomings identified. Further recommendations included consideration of national guidance for the management of skin wounds and a reminder about the need for comprehensive record keeping.

## Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case Reference 201501209 – Report issued in June 2016

Mr E complained that there was a lack of investigation and treatment of his late wife's falls over a number of years. The Ombudsman found that Abertawe Bro Morgannwg University Health Board's ("the Health Board") actions fell short of good clinical practice and were contrary to relevant guidance. As Mrs E had multiple hospital attendances as a result of falls, she should have been referred to a specialist falls services to assess/investigate her falls. This may have resulted in interventions that could have prevented the falls and injuries Mrs E sustained as a result of these. The Ombudsman upheld Mr E's complaint.

A number of recommendations were made which included an apology for the identified failings and redress of £250 for the distress caused by these. The Ombudsman also recommended that Emergency Department ("ED") staff should be reminded of the importance of following the Health Board's community falls pathway for patients over 65 years old and that it should review ED arrangements to ensure that patients identified as at risk of falls are dealt with in line with relevant guidance. The Health Board agreed to implement the recommendations.

## Cwm Taf University Health Board – Clinical treatment in hospital Case Number: 201503626 – Report issued in June 2016

Mr X complained he had two circumcisions, on the first occasion too much foreskin had been left which led to phimosis (foreskin will not retract). After his second circumcision Mr X said too much skin had been removed, which had reduced his penis to half its original size, reduced his urine flow, caused stabbing pain in his urethra and the procedure had left him impotent.

The following aspects of the complaint were upheld:

- Mr X was overweight and diabetic, and the complication of developing a trapped penis had not been explained to him
- the relationship between Mr X and Cwm Taf University Health Board ("the Health Board") had deteriorated and it was unclear whether Mr X had been informed that he could access a neighbouring health board's consultant urologist.

The Ombudsman recommended the Health Board:

- a) apologise to Mr X for not explaining to him the complication of developing a trapped penis
- b) ensure Mr X was aware he could access a neighbouring health board's consultant urologist.

## Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Reference 201502644 – Report issued in June 2016

Mr N complained about the management and care his late father, Mr B, received in the days leading up to and including his death at Glan Clwyd Hospital (“the Hospital”). Mr B had a pre-existing abdominal aortic aneurysm (where a weakness in the artery wall causes bulging) which was being monitored. He had recently been diagnosed with terminal cancer. A post-mortem revealed that Mr B’s aneurysm had ruptured leading to his death. Finally, Mr N expressed dissatisfaction with Betsi Cadwaladr University Health Board’s (“the Health Board”) handling of his complaint.

The Ombudsman having taken into account clinical advice concluded that even if a leaking aneurysm had been identified surgical intervention would not have been appropriate. The Ombudsman having found no significant failings in the management of Mr B’s care did not uphold Mr N’s complaint in respect of service failings.

The Ombudsman felt opportunities existed for clinicians to have communicated more effectively with Mr B and/or his family about the management of his aneurysm should it leak/rupture including the appropriateness of resuscitation. The Ombudsman also criticised record keeping by clinicians and the Health Board’s handling of Mr N’s complaint. He upheld these aspects of Mr N’s complaint.

The Ombudsman recommended the Health Board apologise and pay £750 to Mr N for the failings as well as learn lessons from Mr B’s case.

## Betsi Cadwaladr University Health Board – Clinical treatment in hospital Case Reference 201501506 – Report issued in June 2016

Miss X complained about the care and treatment that she received from the Urology Department at Glan Clwyd Hospital. (“the hospital”) The complaint referred to substantial delays from 2012 in Miss X receiving surgery, diagnostic tests and follow up appointments for her kidney condition. Miss X also expressed concerns about Betsi Cadwaladr University Health Board’s (“the Health Board”) complaint response.

The Ombudsman found a catalogue of errors in Miss X’s case. He said that it was unacceptable that ‘urgent’ appointments and surgery took so long to be actioned. He also found repeated failures in the booking of investigations and follow up appointments. The Ombudsman was critical of the access and communication arrangements within the Urology Department.

The Ombudsman, taking account of clinical advice, was of the view that there was clearly an injustice to Miss X. He said she suffered additional discomfort and distress as a result of the delays. The Ombudsman found that there was no direct evidence to suggest that there had been irreversible damage to Miss X’s kidney. However, he said that unnecessary uncertainty had been created for Miss X. The Ombudsman upheld Miss X’s complaint about her clinical care. The Ombudsman also found some shortcomings in the Health Board’s complaint response and to the extent of these, upheld Miss X’s complaint.

The Ombudsman recommended that the Health Board apologise and provide financial redress to Miss X of £2,750. He also recommended that the Health Board reviews its arrangements for managing bookings, and ensures the adequacy of administrative support and escalation procedures.

## IDH My Dentist – Clinical treatment outside hospital

### Case Reference 201503157 - Report issued in June 2016

Ms X complained about a Dental Practice in the area of Hywel Dda University Health Board. Ms X referred to having suffered unnecessary pain, having a poorly completed filling and said that her dental needs had not been adequately assessed.

Ms X also complained about the response provided to her complaint by the Dental Practice. The Ombudsman took advice from one of his Dental Advisers and he found that there had been shortcomings in the dental care and treatment provided to Ms X.

The Ombudsman was of the view that there had been some injustice to Ms X particularly as her treatment should have been timelier and said that a degree of uncertainty, inconvenience and distress had been suffered by Ms X. To the extent of the identified shortcomings the Ombudsman upheld Ms X's complaints about her clinical care. He also upheld Ms X's concerns about the complaint response which she had received.

The Ombudsman recommended that the Dental Practice provide an apology and financial redress of £774 to Ms X and review its systems and processes.

## Aneurin Bevan University Health Board – Clinical treatment in hospital

### Case Reference 201505689 – Report issued in June 2016

Mrs X complained about the care and treatment her late husband, Mr X, received during an admission to hospital. Mrs X complained that Mr X was prescribed medication despite informing clinicians that he had an adverse reaction to it; that there was a failure to administer treatment to remove fluid from Mr X's lungs; there was a failure to monitor Mr X; that Mr X had been unnecessarily catheterised; and that there was a failure to complete medical records.

Mrs X also complained that Aneurin Bevan University Health Board ("the Health Board") failed to adequately respond to her complaint.

The investigation found that there was no evidence that the medication prescribed had an adverse effect on Mr X's condition and, unfortunately, despite medical intervention, Mr X deteriorated too quickly and sadly died. The investigation found no evidence to suggest that Mr X had been unnecessarily catheterised and the medical records were of a reasonable standard.

Finally, the investigation found that the Health Board had failed to provide Mrs X with a full response to her complaint. Instead, it provided a chronology of events.

It was recommended that the Health Board apologise to Mrs X for the failings identified and provide guidance to relevant officers on drafting meaningful complaint responses.

## Betsi Cadwaladr University Health Board – Clinical treatment in hospital

### Case Reference 201501306 – Report issued in June 2016

Mr C complained about the way in which Betsi Cadwaladr University Health Board (“the Health Board”) treated his oesophageal achalasia (“OA”). He suggested that its response to his OA was unreasonably delayed, that it took too long to address his nutritional needs after his admission to hospital, that it pressurised him into having further dilatation, and that it failed to recognise that he was at increased risk of oesophageal perforation (“OP”). He also complained that its initial treatment of his OP was deficient.

The Ombudsman found that the Health Board took too long to type two key treatment-related letters. He partly upheld that aspect of Mr C’s complaint, which concerned the Health Board’s management of his OA, solely because of this administrative failing. He did not uphold that part of it, which was about the Health Board’s initial response to his OP. The Ombudsman recommended that the Health Board should write to Mr C to apologise for the failing identified and take urgent action to address the administrative resource shortfall associated with it.

The Health Board agreed to implement these recommendations.

## Hywel Dda University Health Board - Patient list issues

### Case Reference 201501761 – Report issued in June 2016

Mr B complained to the Ombudsman that when Hywel Dda University Health Board (“the Health Board”) placed him on its waiting list for a cataract operation, it gave him misleading information about the length of time he would have to wait for the procedure (three to five months when the actual waiting time was around twelve months). He also complained that the Health Board failed to respond to repeated queries about what alternative options were available for him to receive the cataract operation.

Mr B said that as a result of this lack of response from the Health Board about the options available to him he had no choice but to fund his cataract surgery himself.

Finally, Mr B complained that the Health Board took nine months to respond to his complaint despite a number of interventions by the Ombudsman.

The Ombudsman upheld all aspects of Mr B’s complaints. He found that the Health Board had misled Mr B in terms of his likely waiting time for surgery and repeatedly failed to respond for his query about alternative options which gave Mr B little option than to fund the procedure himself. He also found that the complaint response had been delayed unreasonably and had failed to explain how it was dealing with his concern from the outset. The Ombudsman recommended that the Health Board provide £250, £2,000 and £500 for these failings respectively.

## Hywel Dda University Health Board – Clinical treatment in hospital

### Case Reference 201503319 – Report issued in June 2016

Mrs D complained that her father, Mr D, who had Parkinson’s disease, had suffered a dislocation of his jaw whilst in Glangwili Hospital (“the Hospital”) and that staff had failed to identify and treat the dislocation appropriately. She also complained about a delay in providing pain relief to her father once the dislocation was brought to their attention and that nursing staff had been rude to her when she raised concerns about the dislocation with them.



The Ombudsman found that missing Mr D's dislocation did not amount to a failure on the part of staff because of the relative difficulty in identifying it in Mr D's case. He also considered that the provision of pain relief had been appropriate once the dislocation had been identified. The Health Board acknowledged that staff had been "short" with Mrs D at the time and apologised to her and arranged for staff to receive training. Whilst the Ombudsman upheld this aspect of the complaint he found that no further action was necessary.

The Health Board had also implemented an action plan with a view to trying to reduce the likelihood of a recurrence. The Ombudsman found no failing with the care provided to Mr D although he invited the Health Board to undertake an audit of nursing records to ensure there is appropriate recording of any slips, trips or falls which was identified as a shortcoming during the investigation.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital**

### **Case Reference 201503891 – Report issued in June 2016**

Mrs D complained to the Ombudsman about a delay in referring her for a second opinion to determine the cause of abdominal pain she had been experiencing over a three year period.

The Ombudsman found that the Betsi Cadwaladr University Health Board ("the Health Board") had acted appropriately to initially investigate the cause of Mrs D's pain. However, once these "frontline" investigations had been exhausted the Ombudsman considered that the Health Board should have considered arranging for Mrs D to receive a second opinion. Whilst the referral was eventually made to another Health Trust, the Ombudsman considered there had been a delay of 15 months in arranging this.

He upheld the complaint and recommended that the Health Board apologise to Mrs D and pay her redress of £500. He also recommended that the Health Board review its referral pathways for patients to upper gastrointestinal specialist centres and that it strengthen its mechanisms for discussing patients at MDT meetings.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital**

### **Case Reference 201501827 – Report issued in June 2016**

Mrs X complained about the care and treatment her father, Mr Y, received during his admission to Ysbyty Alltwn (the hospital") between 15 December 2011 and 13 January 2012. In particular, she questioned why Mr Y did not receive anti-sickness injections as a preventative measure. Mrs X also complained that adequate records of Mr Y's food and fluid intake had not been kept at all times and a bone scan was not ordered for Mr Y.

Mrs X also said that the family were not kept adequately informed as to Mr Y's condition. Mrs X complained that Mr Y was not transferred to Ysbyty Gwynedd between 15 - 21 December. She complained that adequate records were not kept about Mr Y's fall on 11 January 2012. Mrs X complained about the handling of her complaint.

The Ombudsman found that Mr Y did receive anti-sickness injections appropriately. He found that adequate records were not kept of Mr Y's food and fluid intake and therefore upheld the complaint. A bone scan had been ordered for Mr Y. The Ombudsman found that there had been adequate communication with the family regarding Mr X's condition. The Ombudsman found that adequate

medical records had not been kept of Mr Y's fall, although the nursing records made were reasonable, and partly upheld the complaint. The Ombudsman also upheld Mrs X's complaint about a delayed complaint response.

The Ombudsman made a number of recommendations, including an apology to Mrs X for the identified failings. He recommended a payment of £250 in respect of the delayed complaint response. He also recommended that relevant nursing and medical staff be reminded of the importance of record keeping.

## NOT UPHELD

### Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital Case reference 201500785 – Report issued in April 2016

Mr D complained about the care and treatment he received from Abertawe Bro Morgannwg University Health Board ("the Health Board") between 2007 and 2014.

The specific complaints the Ombudsman investigated were that:

- a) the Health Board failed to appropriately manage Mr D's complaint
- b) the Health Board failed to treat Mr D's open wound within a reasonable length of time
- c) the Health Board failed to adequately manage Mr D's heart condition
- d) the Health Board failed to adequately assess and treat Mr D's back pain, and
- e) Mr D was inappropriately discharged from the Princess of Wales Hospital on 15 April 2013.

With regard to the first complaint, during the course of the investigation the Health Board acknowledged that there was a delay in responding to Mr D's complaint. It offered Mr D an apology and a payment of £250 in recognition of this. Consequently, the Ombudsman considered this element of the complaint to be settled.

With regard to Mr D's second complaint the Ombudsman found that, although the Health Board failed to meet its Referral to Treatment Target (RTT) by two weeks, this was justified under the circumstances as Mr D required cardiac treatment which meant that he was unsuitable for surgery.

With regard to Mr D's third complaint, the Ombudsman found that Mr D's cardiology care was appropriate and in line with relevant guidance.

With regard to Mr D's fourth complaint, the Ombudsman found some failings during Mr D's assessment, in particular, that the Health Board should have considered undertaking an MRI scan. However, a later MRI scan confirmed that Mr D did not require surgery. That being so, the Ombudsman was of the view that this did not appear to have caused Mr D any additional harm. Finally, there was no evidence to suggest that the management of Mr D's discharge from the Hospital was unsafe. Therefore the Ombudsman did not uphold the complaint.

### Cwm Taf University Health Board - Clinical treatment in hospital Case reference 201503562 – Report issued in April 2016

Mrs K complained about several aspects of the standard of care provided to her late mother, Mrs J at Ysbyty Cwm Rhondda in 2014. The Ombudsman obtained clinical advice on the complaint. He found that there were no shortcomings in the management of Mrs J's medication or condition. There was

no additional treatment that could have been offered to her. The Ombudsman did not uphold the complaint.

However, he noted that some of the recording by one clinician (who had since retired) was poor and lacked detail. Cwm Taf University Health Board ("the Health Board") had also previously apologised to Mrs K that the fluid balance charts had not been completed to an acceptable standard.

The Ombudsman suggested that the Health Board should consider the following points:

- a) how clinical cover is provided on the relevant wards to ensure that patients are regularly reviewed
- b) how to ensure that a good standard of nursing and medical record keeping is maintained (by having an effective audit system), and
- c) how to promote effective communication with patients and relatives by both medical and nursing staff about a patient's condition and treatment.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital**

### **Case reference 201504401 – Report issued in April 2016**

Mr X complained about the failure to take a lymph node biopsy in respect of his late wife, Mrs X. He said such a biopsy would have given a more accurate diagnosis of her illness and its poor prognosis. He said she was denied the opportunity to elect for palliative treatment from the outset instead of the aggressive chemotherapy she underwent.

The Ombudsman found that a lymph node biopsy was not indicated, would not have provided any additional information and would not have altered Mrs X's treatment plan. The Ombudsman concluded that the care Mrs X received in this respect was appropriate and did not uphold the complaint.

## **Abertawe Bro Morgannwg University Health Board – Continuing Care**

### **Case reference 201501762 – Report issued in April 2016**

Mr Z complained about Abertawe Bro Morgannwg University Health Board ("the Health Board"), and the Independent Review Panel's ("IRP") consideration and decision about his retrospective claim for NHS funded healthcare ("CHC") for his late mother.

The Ombudsman's investigation found that the Health Board and the IRP had followed the procedure set out in the Welsh Government guidance; had considered all the available evidence; and had applied the relevant tests in reaching the decision that his late mother was not eligible for CHC.

The Ombudsman did not uphold Mr Z's complaint.

## **Betsi Cadwaladr University Health Board - Clinical treatment in hospital**

### **Case reference 201504386 - Report issued in May 2016**

Miss A complained about the treatment her late mother, Mrs B, received for her cardiac condition from January 2013. Mrs B sadly died in October 2014. In particular, Miss A complained that an angioplasty was not offered sooner and that by the time Mrs B did have an angioplasty her condition had deteriorated so much that it was ineffective. Miss A also complained about delays in Betsi Cadwaladr University Health Board's ("the Health Board") response to her complaint.

The Ombudsman found that Mrs B's condition was appropriately treated, although communication regarding treatment options could have been better. He found that the Health Board had offered apologies for its poor complaint handling. The Ombudsman did not uphold the complaints.

## Cardiff and Vale University Health Board – Clinical treatment in hospital

### Case reference 201505559 - Report issued in May 2016

Miss F complained about the treatment she received at the Gynaecology Department of Cardiff and Vale University Health Board ("the Health Board"), between 21 October and 14 November 2014, following a termination of pregnancy.

Miss F underwent a termination of pregnancy on 22 October 2014 and completed the procedure on 24 October. Following this, Miss F suffered heavy vaginal bleeding. She attended the Hospital's Emergency Department on two occasions prior to being transferred to the Hospital by ambulance on 14 November. She underwent an emergency procedure to remove pregnancy tissue from the womb and required four units of blood transfused.

It was found that Miss F experienced an unfortunate complication of pregnancy termination, which was managed appropriately by the Health Board. As such, the complaint was not upheld and no recommendations were made.

## Powys Teaching Health Board - Continuing care

### Case Reference 201502081 – Report issued in May 2016

A firm of solicitors made a complaint about the decision that had been made in respect of eligibility for NHS Funded Continuing Care (NHSFCC) for Mrs X. The legal representative said that the primary health need approach was not properly considered. He also said that the evidence supported NHSFCC eligibility (particularly from 8 December 2002 to 18 June 2003). The legal representative also complained about the lack of entitlement to an Independent Review Panel (IRP).

Taking account of clinical advice, the Ombudsman was of the view that a reasonable assessment had been carried out in Mrs X's case and said that the correct approach had been adopted.

The Ombudsman found that Mrs X's claim for retrospective NHSFCC had been managed in line with the relevant Welsh Government guidance. He also said that the Health Board had been reasonable in not identifying an 'element of doubt'. In this circumstance, the Ombudsman said there was nothing to suggest that an IRP should have been held. The Ombudsman did not uphold the complaint.

## Hywel Dda University Health Board & Pembrokeshire County Council - Other

### Case Reference 201502572 & 201504680 – Report issued in June 2016

Mr Y complained about the care his wife received during the short period she lived at a care home, resulting in a deterioration in her condition and the need for her to be admitted to hospital. Mrs Y's care was funded partly by the Council and partly by the Health Board.

The Ombudsman found nothing to suggest that Mrs Y's deterioration was as a result of any lack of care on the part of the care home. He did not uphold the complaint.

## Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Reference 201500269 – Report issued in June 2016

Mr X complained that, despite being seen by numerous clinicians, they were not able to establish that he might be suffering from sleep apnoea (the absence of breathing during sleep despite continuing respiratory effort) and refer him to the correct department, meaning he was left to suffer with the symptoms untreated for a number of years.

The investigation found that while sleep apnoea could have been investigated and diagnosed sooner than it was, the delay in diagnosing Mr X's condition was not as a result of an unreasonable standard of care on the part of the clinicians involved in his case. The complaint was therefore not upheld.

## Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

Case Reference -201501027 - Report issued in June 2016

Mrs X complained about a failure to provide adequate/timely pain relief during child birth. The Ombudsman found that she did not receive ideal care but in the circumstances at the time, the care did not amount to service failure. The complaint was not upheld.

## EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

### Powys Teaching Health Board – Continuing Care

Case reference 201506835 – Report issued in April 2016

Mrs A complained about shortcomings in the process which had taken place in respect of the consideration of her late mother's (Mrs B) eligibility for NHS Funded Continuing Care. She was particularly concerned that an Independent Review Panel (IRP) went ahead without the relevant Clinical Advisor being present. She noted that the IRP did not have an opportunity to discuss significant questions raised with the Advisor and consider the rationale behind her earlier decision making. Mrs A highlighted that the changes made at the negotiation meeting could not be satisfactorily considered by the IRP.

A settlement was reached in this case as Powys Teaching Health Board agreed to arrange for a newly constituted IRP to consider Mrs B's case with the relevant Clinical Advisor being in attendance. It also agreed to apologise to Mrs A for this being a necessary outcome.

### Hywel Dda University Health Board – Clinical treatment in hospital

Case reference 201506695 – Report issued in April 2016

Mrs X complained about the delays encountered with Hywel Dda University Health Board ("the Health Board") in responding to her concerns regarding the treatment of her late father.

The Ombudsman advised Mrs X that investigations by a Health Board regarding concerns of a very sensitive and serious nature may take longer than initially expected but that it was recognised that, in a letter dated 5 January 2016, the Health Board advised that its investigations were nearing completion and a response was imminent.

Concerns were therefore expressed to the Health Board that, three months following that letter, a response had still not been received. It therefore agreed to write to Mrs X with a full response within ten working days.

## **Betsi Cadwaladr University Health Board - Clinical treatment in hospital** **Case reference 201507146 – report issued in April 2016**

Miss A complained to the Ombudsman that she made a complaint to Betsi Cadwaladr University Health Board (“the Health Board”) in November 2015; however it had failed to respond.

After contacting the Health Board the Ombudsman established that an offer of a meeting was made to Miss A to discuss her concerns; however Miss A declined this. The Health Board failed to follow up in writing.

Therefore the Ombudsman asked the Health Board to:

- a) expedite an investigation and respond to Miss A as soon as possible, and
- b) offer Miss A a payment of £100 for failure to respond to the complaint with a letter of apology while she is awaiting the response.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital** **Case reference 201506559 – Report issued in April 2016**

Mr B complained to the Ombudsman about Betsi Cadwaladr University Health Board’s (“the Health Board”) delay in responding to a complaint submitted under the Putting Things Right process.

Mr B had expressed concerns about the care and treatment afforded to a close family member whilst in hospital. The Ombudsman contacted the Health Board to discuss the complaint and they agreed to the following recommendations:

- a) expedite its final response to Mr B
- b) to provide the response within three weeks, and
- c) to apologise for delay.

## **Aneurin Bevan University Health Board - Clinical treatment in hospital** **Case reference 201600073 - Report issued in April 2016**

Mr X complained that he was yet to receive a comprehensive final response after making a complaint to Aneurin Bevan University Health Board (“the Health Board”) in December 2015.

On receipt of the complaint, the Ombudsman contacted the Health Board which agreed to provide its response at the earliest possible date. The response has since been issued.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital** **Case reference 201506940 - Report issued in April 2016**

Mrs X complained to the Ombudsman that Betsi Cadwaladr University Health Board (“the Health Board”) had failed to meet its six week target to provide a response to all outstanding issues. Mrs X had initially complained to the Health Board in June 2014.

The Ombudsman contacted the Health Board to discuss the complaint and they agreed to the following

recommendations:

- a) to apologise for the current delay and provide an update
- b) to expedite its full response
- c) to pay Mrs X the sum of £50 in recognition of the ongoing delay.

#### **Cwm Taf University Health Board - Clinical treatment in hospital**

**Case reference 201506542 - Report issued in April 2016**

Mrs D complained about the standard of care and treatment that her father received whilst he was a patient at the Royal Glamorgan Hospital. Mrs D complained to Cwm Taf University Health Board ("the Health Board") in April 2015, and received the Health Board's response by letter dated 30 September 2015. However, Mrs D complained that she was struggling to get a full picture of the care given to her father, and there were voids in the time frame for which she had not received an explanation from the Health Board.

On receipt of the complaint, the Ombudsman considered that it would be helpful for Mrs D to meet with the Health Board to discuss the outstanding issues. Following a discussion with the Health Board, it agreed to contact Mrs D directly within two weeks from the date of the decision letter being issued in order to arrange a convenient date when Mrs D could meet with the Health Board.

#### **Betsi Cadwaladr University Health Board - Clinical treatment in hospital**

**Case reference 201506987 - Report issued in April 2016**

Mr A first complained to the Ombudsman in February 2016 because he had not received a response to a complaint made in October 2015 about his care and treatment. At that time Betsi Cadwaladr University Health Board ("the Health Board") gave an undertaking to respond to Mr A in full. Six weeks later, Mr A subsequently contacted the Ombudsman to complain that he had still not received the response.

The Health Board agreed to the following recommendations:

- a) to expedite the completion of its full response, and
- b) to pay Mr A the sum of £50 in recognition of the distress caused by the delay

#### **Hywel Dda University Health Board – Clinical treatment in hospital**

**Case reference 201506276 - Report issued in April 2016**

Ms X complained that after submitting a complaint to Hywel Dda University Health Board ("the Health Board"), concerning the care and treatment provided to her late father, there was a meeting in November 2015 where some of her concerns were addressed but not all of them. However, at the time of submitting her complaint to the Ombudsman she had still not received a copy of the meeting minutes.

On receipt of her complaint, the Ombudsman contacted the Health Board which agreed to send Mrs X a copy of the meeting minutes together with an apology. Ms X was advised that if the meeting minutes did not materialise or if she was not satisfied with the contents of them or how the Health Board had dealt with her complaint she could come back to the Ombudsman.

## Aneurin Bevan University Health Board – Clinical treatment in hospital

Case reference 201506750 - Report issued in April 2016

Mr A complained to the Ombudsman that he was not notified of biopsy results, despite numerous attempts to contact the department, and then had to wait for a follow-up appointment. Mr A also said that when he complained to Aneurin Bevan University Health Board (“the Health Board”) it was not clear who was his point of contact and the two members of staff he dealt with did not keep in contact regularly, or progress the complaint in a timely manner.

The Ombudsman found that communication was unclear and inconsistent, and there were protracted periods where the Health Board failed to make contact with the complainant. The investigation further found that the Health Board failed to adhere to the Putting Things Right policy in terms of keeping the complainant informed and managing his expectations.

The Ombudsman recommended the following actions which the Health Board agreed to:

- a) a full apology for the failures in communication and complaint handling
- b) a sum of £250 offered to reflect the time, trouble and additional distress.

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

Case reference 201504737 - Report issued in April 2016

Mrs A complained to the Ombudsman about Betsi Cadwaladr University Health Board’s (“the Health Board”) decision to allow her son to go home from hospital over the Christmas period. Mrs A said the decision was inappropriate because there was an ongoing Protection Of Vulnerable Adults (POVA) investigation concerning an allegation of harm caused by another resident at the care home where he lived.

On receipt of the complaint, the Ombudsman contact the Health Board and it agreed to liaise with Conwy County Borough Council to conduct a joint investigation to consider whether the potential ongoing risk to Mrs A’s son was appropriately managed during the course of the POVA investigation.

## Abertawe Bro Morgannwg University Health Board - Clinical treatment in hospital

Case reference 201506561 - Report issued in April 2016

Mrs X complained to the Ombudsman about her late husband’s treatment and care and the circumstances of his death at the Princess of Wales Hospital on 11 November 2014. Mr X’s medical records had been mislaid by Abertawe Bro Morgannwg University Health Board (“the Health Board”) and the Ombudsman was not able to carry out an independent investigation of Mrs X’s concerns.

The Ombudsman contacted the Health Board and proposed that there was further action it could take in settlement of the complaint and it agreed to undertake the following:

- a) continue to actively search for the medical records
- b) if, after the period of one month, the records have failed to materialise, apologise in writing to Mrs X and make a payment to her of £1750 in recognition of the injustice caused by not being able to have



her complaint independently investigated.

- c) make an additional payment to Mrs X of £750, in recognition of the significant and ongoing distress caused by the acknowledged failure to lay her husband's body out in a respectful and fitting manner and her witnessed dispute between a doctor and nurse about the circumstances of his death.
- d) within two months of the date of this decision, carry out a root cause analysis of the loss of the records.
- e) continue to actively search for the medical records for a period of six months and provide a final update to Mrs X, explaining the action taken to locate the records and the outcome of the root cause analysis.

## Hywel Dda University Health Board – Clinical treatment in hospital

### Case reference 201505770 - Report issued in April 2016

After a complaint was submitted to Hywel Dda University Health Board ("the Health Board") on 25 November 2014, Mrs X complained to the Ombudsman that Hywel Dda University Health Board's ("the Health Board") final response remained outstanding.

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

- a) provide both Mrs X and her advocate at the Community Health Council with an apology and full reasons for the delay in responding to the complaint
- b) provide Mrs X with a payment of £500 in recognition of the time and trouble in having to bring the complaint to the Ombudsman, the Health Board's failure to provide meaningful updates to both Mrs X and her advocate and the delay in providing a response.

## Betsi Cadwaladr University Health Board – Continuing Care

### Case Reference 201600348 - Report issued in May 2016

In January 2016 Mr C complained to Betsi Cadwaladr University Health Board ("the Health Board") about its decision to not review, re-calculate and pay a different level of interest rate in relation to a previously settled Continuing Health Care case. Mr C was also unhappy that he had gone to a considerable amount of time and effort to gather together personal financial documentation over a period of six months. Mr C then approached the Ombudsman as he was unhappy at why it had refused his application.

On receipt and assessment of the complaint, the Ombudsman found that whilst it was reasonable to refuse Mr C's application, the Health Board had in fact raised Mr C's expectations by suggesting it would re-calculate the interest rate.

The Ombudsman contacted the Health Board and it agreed to resolve the complaint on the following basis:

1. to write a letter of apology for unnecessarily raising Mr C's expectations, and
2. make a payment to Mr C of £250 in recognition of the time and trouble in retrieving documentation over a six month period.

## Aneurin Bevan University Health Board – Clinical treatment in hospital

Case Reference 201600160 – Report issued in May 2016

Mrs P complained that the treatment her sister received was substandard, which resulted in her deterioration and subsequent death. Mrs P raised concerns regarding the provision of medication and pain relief as well as staff approach and attitude. Mrs P further complained that Aneurin Bevan University Health Board (“the Health Board”) had failed to provide a response to your concerns within a reasonable time period.

The investigation found that although the Health Board had intended to provide a response, Mrs P had been awaiting the conclusion of the investigation for six months, which is outside of the Ombudsman’s guidelines. The investigation also found that until the Health Board had concluded their report, no determination could be made as to whether any maladministration or service failure had taken place in terms of patient care.

The Ombudsman therefore recommended the following actions to be undertaken:

- (a) an apology be given for the significant delays in response time
- (b) an offer of £100 financial redress be made
- (c) the investigation to be concluded and the final response expedited.

## IDH My Dentist – Other

Case Reference 201600933 – Report issued in May 2016

Mr W initially complained to Hywel Dda University Health Board (“the Health Board”) in November 2014 about the treatment he had received at Robert Street Dental Practice. The Health Board passed the complaint to the Dental Practice which responded to Mr W on 13 April 2015. Mr W was unhappy with the response, therefore he wrote a further letter to the Health Board on 23 April 2015, detailing his outstanding concerns about the dental treatment he received.

On receipt of the complaint, the Ombudsman noted that the Dental Practice had not had not seen a copy of Mr W’s further letter to the Health Board, therefore it was not aware of his outstanding concerns.

The Ombudsman contacted the Dental Practice to discuss Mr W’s concerns and it agreed to provide a written response to the concerns as outlined in Mr W’s letter to the Health Board by 7 July 2016.

## Cwm Taf University Health Board - Clinical treatment in hospital

Case Reference 201600808 – Report issued in May 2016

Mr A raised a complaint about the length of time it had taken Cwm Taf University Health Board (“the Health Board”) to consider a complaint about care and treatment he received whilst a patient at Prince Charles Hospital. Mr A made a complaint in April 2015 however had not yet received a response.

The Health Board confirmed that this complaint was a complex case and an update letter had been recently sent explaining the Health Board’s position.

The Health Board agreed to offer Mr A a payment of £100 for the delay in the complaint process.

## Hywel Dda University Health Board - Clinical treatment in hospital

### Case Reference 201600813 – Report issued in May 2016

Mrs A complained that Hywel Dda University Health Board (“the Health Board”) had failed to recognise or take seriously a gynaecological issue that had resulted in her and her husband being unable to naturally have children. Mrs A complained about the length of time that had elapsed for an operation which could have been avoided. Mrs A said she felt let down by both the GP and Hospital.

On receipt of the complaint, the Ombudsman contacted the Health Board to establish its position in considering the complaint and whether a response to the concerns raised in July 2015 was near completion. The Health Board responded and informed the Ombudsman that a response was nearly complete.

The Health Board agreed to:

- (a) provide an apology for the continued delay
- (b) offer Mrs A a payment of £100 for the time and trouble in having to bring a complaint and the delay in the Health Board responded to the concerns raised, and
- (c) provide Mrs A with a response to her concerns by 31 May 2016.

## Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital

### Case Reference 201503893 Report issued in May 2016

Ms A complained on behalf of her son about the care and treatment that her son received following a sports related injury to his left knee in 2014. From a complaint handling perspective, Mrs A also complained about the communication difficulties that she encountered, particularly in the period following her son’s operation.

As Ms A’s son had decided to go down the route of legal action the Ombudsman discontinued his investigation into the clinical aspect of the complaint.

The Ombudsman reached a settlement with the Health Board on the complaint handling aspect of Ms A’s complaint. The terms of the settlement was that the Health Board should make a payment of £250 for the inconvenience and difficulties caused by the shortcomings in communication.

## Cardiff and Vale University LHB - Clinical treatment in hospital

### Case reference 201600947 – report issued in June 2016

Mr A complained that whilst he was admitted to the University Hospital of Wales in June 2013 he contracted Hepatitis C. Although this matter was subject of an internal investigation by Cardiff and Vale University Health Board (“the Health Board”) it was unable to identify the source of infection. Mr A expressed concern that the Health Board had failed to take accountability. Further Mr A complained about the length of time taken by the Health Board to investigate the matter and provide a report of its findings.

Having considered the complaint the Ombudsman found that although the Health Board’s internal investigation had been extensive, sadly, it had failed to conclusively identify the source of the infection. It

was felt that little further could be achieved through an investigation of Mr B's complaint.

However on receipt of the complaint, the Ombudsman contacted the Health Board and it accepted that there had been an unreasonable delay in providing Mr A with a copy of the investigation report. In recognition of this the Health Board agreed to:

- a) apologise to Mr A
- b) pay £250 to Mr A for the time and trouble taken to pursue his complaint
- c) ensure that internal investigations are completed in line with the Putting Things Right regulations and timelines.

### **Betsi Cadwaladr University Health Board - Clinical treatment in hospital**

#### **Case reference 201601048 - Report issued in June 2016**

Mr M complained about the care and treatment provided to his father and requested a full investigation into Betsi Cadwaladr University Health Board's ("the Health Board") role in the events leading up to his death. The Health Board provided an initial response regarding the short time Mr M's father was under its care. However, following a further complaint from Mr M, the Health Board deemed a review was warranted and conducted a second investigation.

The Ombudsman found that the second investigation was reasonable and appropriate and the Health Board demonstrated a reasonable standard of care. However, the consequence of the review meant a subsequent delay of 5 months for Mr M to receive a full and final response.

Therefore the Health Board agreed to provide a written apology to Mr M for the inconvenience in having to raise further concerns to prompt a more complete investigation and the delay in issuing an ultimate response.

### **Abertawe Bro Morgannwg University Health Board – Clinical treatment in hospital**

#### **Case reference 201600304 - Report issued in June 2016**

Mrs X complained about her late husband's treatment and care and the circumstances of his death at the Princess of Wales Hospital on 11 November 2014. At the time of the complaint to the Ombudsman, Mr X's medical records had been mislaid by Abertawe Bro Morgannwg University Health Board ("the Health Board") and it had not been able to respond fully to the concerns Mrs X had raised. The Health Board continued its search for the records and they were located. In view of this, the Ombudsman asked the Health Board, and it agreed, to undertake the following in settlement of the complaint:

- a) provide Mrs X with an explanation for the loss of her husband's medical records and any measures taken to ensure that this does not happen again
- b) expedite a full complaint response to Mrs X
- c) apologise to Mrs X and pay her £250 in recognition of the delay and continuing doubt over Mr X's treatment and care caused by the loss of the records.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital**

**Case reference 201600226 - Report issued in June 2016**

Mrs G raised an informal complaint with Betsi Cadwaladr University Health Board (“the Health Board”) on 4 August 2014, regarding the treatment she received at the Emergency Department at Wrexham Maelor Hospital, following her attendance on 23 May 2014. Mrs G met with representatives to discuss her concerns but felt that the meeting was unsatisfactory and lacked explanation. Mrs G therefore wrote a formal complaint letter to the Health Board on 1 June 2015 but following its response Mrs G was unhappy.

Mrs G wrote a further letter to the Health Board expressing her disappointment and the Health Board provided its final response on 7 March 2016. Mrs G complained to the Ombudsman about the length of time taken by the Health Board to deal with her complaint.

The Ombudsman concluded that there was some delay by the Health Board in dealing with the complaint, and the Health Board had failed to keep Mrs G properly informed about the progress made during the course of its investigation.

The Health Board accepted that the investigation took longer than anticipated and that it could have made more attempts to keep Mrs G informed during its investigation. The Health Board agreed to undertake the following action in settlement of Mrs G’s complaint:

- a) to provide Mrs G with a written apology for the delay in dealing with her complaint
- b) to make an offer of £150.00 in recognition of the distress caused to Mrs G as a result of the delay.

## **Betsi Cadwaladr University Health Board – Clinical treatment in hospital**

**Case reference 201601189 - Report issued in June 2016**

Mrs F complained that she had raised concerns with Betsi Cadwaladr University Health Board (“the Health Board”) in December 2015 but it had only responded to one aspect of her complaint. The Ombudsman found that Mrs F had made two separate complaints which were acknowledged, but the Health Board failed to progress the second complaint appropriately or provide a response to it.

The Health Board agreed to undertake the following action in resolution of this complaint:

- a) expedite an investigation into Mrs F’s clinical concerns and provide a full response within 8 weeks of the Ombudsman’s final notification
- b) apologise in writing for the complaints handling failure and offer a sum of £250 redress within 4 weeks of the Ombudsman’s final notification.

## **Cwm Taf University Health Board - Clinical treatment in hospital**

**Case reference 201600811 - Report issued in June 2016**

A firm of solicitors (“the solicitors”) complained about Cwm Taf University Health Board’s (“the Health Board”) delay in dealing with a complaint submitted by their client, Mrs D and lack of progress. The complaint centred on her mother’s clinical care and was submitted in April 2013. In 2015, the Health Board agreed the complaint should proceed through the Redress provisions of the “Putting Things Right

(PTR) Regulations and to jointly instruct an independent expert in accordance with the PTR provisions. After agreement with the solicitors on the expert the Health Board informed them in December 2015 that it would prepare draft instructions for their approval, and that the expert could give his opinion within 4-6 weeks. The solicitors had heard nothing further by 9 May 2016 when they complained to the Ombudsman.

Having considered the papers submitted to him, the Ombudsman took the decision to seek the Health Board's agreement to resolve the complaint, in accordance with his powers. The Health Board agreed to implement the following actions in full:

- a) send the draft joint letter of instruction to the solicitors for approval within 10 working days
- b) despatch it to the expert within 7 working days of the solicitors agreeing the draft
- c) apologise in writing to Mrs D for the complaint handling failures and ongoing delay (within 20 working days)
- d) offer Mrs D redress of £400 for those complaint handling delays.

### **Betsi Cadwaladr University Health Board - Clinical treatment in hospital**

#### **Case reference 201600848 - Report issued in June 2016**

A firm of solicitors ("the solicitors") complained about the way in which Betsi Cadwaladr University Health Board ("the Health Board") had dealt with a complaint submitted by their client, Mrs A about the care of her late husband, Mr A. They complained to the Ombudsman that the Health Board was failing to comply with the process set down in the Redress provisions of the "Putting Things Right" (PTR) Regulations.

Whilst the Health Board had acknowledged in correspondence that there was a breach of duty relating to Mr A's care, for a small period of time, and so a possible qualifying liability which might lead to redress, it had not agreed to the solicitors' request to jointly instruct an independent expert to assess the care.

In looking at the provisions of the PTR Regulations, the Ombudsman noted that where the Health Board had indicated there may be a qualifying liability; those provisions said that it must proceed to a joint expert instruction. Having considered the papers submitted to him, the Ombudsman took the decision to seek the Health Board's agreement to resolve the complaint, in accordance with his powers. The Health Board agreed to implement the following actions in full:

- a) issue a written apology to Mrs A for its complaint handling failure in this case (within one month)
- b) communicate with the solicitors within 14 working days to agree the appointment of a joint expert and progress the matter under Part 6 of PTR with due diligence thereafter.

### **Hywel Dda University Health Board – Clinical treatment in hospital**

#### **Case reference 201601041 - Report issued in June 2016**

Ms T complained that when she attended Accident and Emergency, Hywel Dda University Health Board ("the Health Board") failed to diagnose her fractured knee. When Ms T returned for a follow-up appointment, she was informed that there was a fracture, and referred for an MRI scan and subsequent surgery. Ms T also complained that although she had received an acknowledgement, she had waited

seven months for a full response.

The Ombudsman requested that the Health Board undertake to provide Ms T with an apology and explanation for the delay, and a timescale within which she could expect a response.

The Health Board issued:

- a) a full response to the complaint
- b) an apology for the delay
- c) details of further action in consideration of qualifying liability

### A GP in the Betsi Cadwaladr University Health Board area- Other Case reference 201600748 - Report issued in June 2016

Mr X complained that his son, who was on holiday in Wales from Malta, was charged for a doctor's appointment and a prescription when he fell ill and attended the local Practice. He complained that his son should not have been charged as he had a valid European Health Insurance Card (EHIC) and that the treatment he needed met the Health Board's Overseas Visitor's Guidance of being 'medically necessary'.

The Ombudsman found that the Health Board guidance included Malta as one of the countries in the European Economic Area where an overseas visitor, with a valid EHIC card, would not need to pay for any 'medically necessary' treatment during a visit to the Betsi Cadwaladr area.

Whilst the Ombudsman did not make a recommendation in relation to the prescription charge, he was satisfied that Mr X's son met the Overseas Visitor's criteria and that his appointment was 'medically necessary'. Therefore, he recommended the following settlement that the Practice agreed to undertake:

- a) send Mr X a cheque for £55 on 10 June 2016 as a refund for the appointment his grandson paid for at the Practice in December 2015
- b) apologise for the inconvenience caused to Mr X in making this complaint

### Aneurin Bevan University Health Board – Clinical treatment in hospital Case Reference 201504372 – Report issued in June 2016

Mrs P complained about her management and care following an early miscarriage. She was also unhappy that she had not been kept updated about any changes that Aneurin Bevan University Health Board ("the Health Board") had introduced as a result of her complaint.

The Ombudsman's investigation confirmed that there had been shortcomings in communication on the part of the Health Board, although he identified that the Health Board had taken steps to address those shortcomings including providing training and making changes to its patient information leaflets.

The Health Board agreed to the additional recommendations that the Ombudsman proposed by way of settlement. These included the Health Board making a further apology, meeting with Mrs P to enable her to feedback her experiences/suggestions as well as providing input into a patient survey. The Ombudsman also made recommendations which focused on training and learning opportunities for clinicians.

Hywel Dda University Health Board - Appointments/admissions/discharge and transfer procedures  
Case Reference 201507159 – Report issued in June 2016

Mr X complained that Hywel Dda University Health Board (“the Health Board”) did not consider his clinical need when assessing his need for surgery. Mr X also complained that the Health Board failed to adequately respond to his complaint in accordance with the “putting things right” process.

In response to the complaint the Health Board accepted that there had been some delays and it was agreed that a settlement could be reached to resolve the complaint to the satisfaction of the Ombudsman.

It was agreed that within one month, the Health Board would:

- (a) apologise to Mr X for the delays he had experienced
- (b) meet with Mr X to discuss his concerns further, provide an explanation for the delays and agree an appropriate figure of redress.



# Complaints handling

## EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

### Powys County Council - Housing

Case reference 201505489 - Report issued in April 2016

In December 2014 Mrs C complained to Powys County Council ("the Council") about the height of her neighbour's hedge. The Council took one year to respond to her complaint when it had indicated it would take 12 weeks. Mrs C then complained to the Ombudsman that she was unhappy at the time taken to respond and the reasons for rejecting her complaint.

On receipt and assessment of the complaint, the Ombudsman contacted the Council to discuss Mrs C's concerns. The Council agreed to resolve the complaint on the following basis:

- a) to apologise for the significant delay in respect of providing a response
- b) to make a payment of £150 by way of an apology in recognition of the delay in responding, and
- c) to visit Mrs C and provide a full explanation as to why her complaint was rejected.

### Aneurin Bevan University Health Board - Health

Case reference 201506314 - Report issued in April 2016

Mr X complained to the Ombudsman that after making his original complaint to Aneurin Bevan University Health Board ("the Health Board") in October 2015, he was still awaiting the Health Board's final response. Mr X also complained that he had also not been sufficiently updated by the Health Board on the progress of the complaint.

On receipt of the complaint, the Ombudsman contacted the Health Board which agreed to provide Mr X with the final response to the complaint.

### Cardiff and Vale University University Health Board - Health

Case reference 201507148 - Report issued in April 2016

Mr X complained to the Ombudsman that he had not yet received a response to a complaint made about his treatment in December 2015. Cardiff and Vale University Health Board explained that the delay was due to the complex nature of Mr X's complaint, but confirmed that:

- b) a review had now been arranged with the various clinical teams involved, and
- c) a written response would be issued within the next seven working days.

## Betsi Cadwaladr University Health Board - Health Case reference 201600136 - Report issued in April 2016

Ms T complained to the Ombudsman on behalf of Mr X about the time it took for Betsi Cadwaladr University Health Board ("the Health Board") to respond to a complaint about treatment for his bowel problems. Ms T made further written representations that month but the Health Board had not responded. Mr X was concerned that the delay might interfere with their right to take legal action.

The Health Board agreed to:

- a) issue a response as soon as possible, and
- b) apologise for the delay.

## Betsi Cadwaladr University Health Board - Health Case reference 201507133 - Report issued in April 2016

Mr A complained about Betsi Cadwaladr University Health Board's ("the Health Board") handling of his complaint against a contracted family health service provider in its area.

On receipt of the complaint, the Ombudsman contacted the Health Board and it accepted that there had been failures in respect of its complaint handling. The Ombudsman found that the Health Board had already taken steps to address the failings identified and little further could be achieved through an investigation of Mr A's complaint.

The Health Board agreed to offer Mr A a formal apology for the poor handling of his complaint and to pay him £150 in recognition of any distress and inconvenience arising

## Betsi Cadwaladr University Health Board – Health Case reference 201505088 - Report issued in April 2016

Mr X complained to the Ombudsman that since the passing of his wife in 2009, he had been unable to "move on" emotionally as he felt that there were unanswered questions surrounding her passing.

On receipt of the complaint, the Ombudsman contacted Betsi Cadwaladr University Health Board ("the Health Board") to seek further clarification on its offer to arrange a meeting to try and resolve any issues. The Health Board agreed to arrange a meeting for the first week of March 2016.

## Betsi Cadwaladr University Health Board - Health Case reference 201600901 - Report issued in June 2016

Ms X complained about the treatment provided to her mother leading up to her diagnosis of colorectal cancer and in particular that a complaint was raised with Betsi Cadwaladr University Health Board ("the Health Board") on 7 July 2015 but, at the time of bringing her complaint to the Ombudsman, she had not received a response.

On receipt of this complaint, the Ombudsman contacted the Health Board to discuss the concerns and the delay in providing a response. He was advised that whilst a response had been drafted, it required checking and signing before it can be finalised. It was expressed to Ms X that, unfortunately, this process can take some time if further information is required and that in this case, the Ombudsman was assured that further clarification was required and, therefore, the complaint was not overlooked.

Ms X was advised that the Ombudsman considered it appropriate to allow the Health Board to retrieve that information in order that it can provide a full explanation.

Prior to providing the final response, the Health Board agreed to:

- a) write to Ms X apologising for the delay and explaining why there had been a delay, and
- b) provide a monetary sum of £200 in recognition of it.

## Education

### UPHELD

#### Ceredigion County Council - Other

##### Case reference 201502409 – Report issued in April 2016

Ms A complained that Ceredigion County Council (“the Council”) failed to facilitate the reintegration of her son (B) into the school environment, the Council’s School Transport Policy was not compliant with Welsh Government guidance and communication issues had been identified by the Council but it had not provided a remedy.

The Ombudsman found that the Council had adopted an intractable approach regarding the completion of two forms, one which Ms A had already completed and a second which she could not complete without information being provided by the Council. This resulted in the breakdown of a planned trial placement in a school for B. He also found that communication difficulties encountered by Ms A should be addressed. The Ombudsman did not uphold Ms A’s complaint about the School Transport Policy as this did not have any impact on the complainant.

The Ombudsman recommended that the Council:

- a) apologise to B
- b) make a redress payment to B of £500 in recognition that the failings identified resulted in a lost opportunity to have a trial placement at a mainstream school
- c) apologise to Ms A
- d) provide financial redress of £100 in recognition of the communication failings already identified
- e) provide complaint handling training for some members of staff, and
- f) review its School Admissions Procedure.

The Council agreed to implement the recommendations.

### EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

#### Student Finance Wales - Other

##### Case reference 201600944 - Report issued in June 2016

Mrs X complained that Student Finance Wales did not clearly communicate the specifications required for the equipment purchased by her daughter, Ms X, and felt that Ms X should be reimbursed for her purchase using her Disabled Student Allowance.

The Ombudsman found that Ms X was given incorrect information by a Student Finance Wales contact member prior to making her purchase. Student Finance Wales agreed to fully reimburse Ms X for her purchase, which was £279.99. Student Finance Wales noted that any further costs incurred in relation to the performance of the equipment would be incurred by Ms X as the equipment was not to the required specification.

## Environment and environmental health

### EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

#### Pembrokeshire County Council – Pollution and pollution control measures

Case reference 201505545 – Report issued in April 2016

Mr X complained that Pembrokeshire County Council (“the Council”) failed to undertake an investigation of his complaint, referred to it in December 2013, on behalf of his sister Miss Y. The Ombudsman commenced an investigation into the Council’s complaints handling of this matter.

Following contact from the Ombudsman and the Council’s review of the papers on this complaint, the Council promptly acknowledged that it had not dealt with Mr X’s complaint in accordance with its complaints policy. Additionally, the Council commenced and completed its formal investigation into Miss Y’s original complaint providing a response within seven weeks thereafter, training for the relevant Complaints Officer, an interdepartmental email to all of the Contact Officers to ensure a clear understanding of their role and responsibilities under the Complaints Policy, and to review and ensure the Council has an up to date procedure manual for its Contact Officers.

#### Blaenau Gwent County Borough Council - Refuse collection, recycling and waste disposal

Case reference 201505684 - Report issued in April 2016

Ms X’s complained to the Ombudsman about the troliblocs system that had been put in place by Blaenau Gwent County Borough Council (“the Council”). Ms X complained that the troliblocs were very heavy and difficult to manoeuvre. Ms X also stated that during bad weather, the troliblocs had a tendency to blow over.

On receipt of the complaint, the Ombudsman contacted the Council which agreed to arrange for a Warden to visit Ms X with the aim of resolving the outstanding issues.

#### Blaenau Gwent County Borough Council - Refuse collection, recycling and waste disposal

Case reference 201505971 - Report issued in April 2016

Mrs X complained that Blaenau Gwent County Borough Council (“the Council”) failed to collect her refuse on a regular basis, and estimated that she was receiving a collection once every six weeks.

On receipt of the complaint, the Ombudsman contacted the Council. The Council agreed to:

- a) ask the Wardens to visit Mrs X’s property on the next refuse collection day to ensure a successful collection was made, and
- b) contact Mrs X via telephone to discuss her concerns.

#### Wrexham County Borough Council - Refuse collection, recycling and waste disposal

Case reference 201600888 - Report issued in June 2016

Mrs A complained that despite raising a concern with Wrexham County Borough Council (“the Council”) about missed refuse collection, further instances occurred.

The Council agreed that further collections had been missed and therefore the Ombudsman recommended that the Council:

- (a) provide Mrs A with a full written apology for the service failure and an explanation of what went wrong
- (b) offer Mrs A £50 in recognition of the service failure.

#### Vale of Glamorgan Council - Other

##### Case Reference 201600929 & 201601060 – Report issued in June 2016

The Ombudsman received a complaint about the way Vale of Glamorgan Council ("the Council") had addressed concerns about a dangerous retaining structure and who would be responsible for its repair and upkeep. The complaint (amongst other things) raised specific concerns about the length of time taken and communication with the owners of the properties affected by the potential hazard.

Following consideration by the Ombudsman, the Council agreed to write to the complainants setting out its response to concerns raised about the time taken in addressing the matter and communication issues.

Other elements of the complaint were outside of the Ombudsman's jurisdiction.

# Finance and taxation

## EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

### Bridgend County Borough Council – Finance and Taxation

Case reference 201600772 - Report issued in June 2016

Mrs X complained that Bridgend County Borough Council (“the Council”) failed to appropriately band her new build property for council tax purposes for two years, resulting in arrears.

The Ombudsman found that the Council had failed to advise Mrs X of the temporary nature of the council tax band that had been applied and further failed to take the necessary steps to ensure that it was revised.

The Ombudsman considered that the Council had already taken reasonable steps to alleviate the financial pressures that the arrears may have caused. However, he contacted the Council and it agreed to:

- a) apologise and
- b) pay a sum of £100 to Mrs X in recognition of any inconvenience caused and her time and trouble in pursuing the complaint.



# Housing

## EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

### Grwp Gwalia Cyf Ltd - Repairs and maintenance

Case reference 201507026 – Report issued in April 2015

Mrs X complained to the Ombudsman about water ingress and dampness problems at her home address resulting in unsatisfactory living conditions and long delays in resolving matters which led to stress and anxiety.

On receipt of the complaint, the Ombudsman contacted Grwp Gwalia Cyf Ltd (“the Housing Association”) for further information and an update. After considering the information provided, the Ombudsman did not consider a detailed investigation was needed as the Housing Association had identified high levels of condensation at the property and taken steps to remedy the issues. Further work had also been proposed to assist with the management of the condensation, and it had offered financial assistance for redecoration.

The Housing Association agreed to undertake the following in settlement of the complaint:

- a) arrange an appointment with Mrs X at her home address within the next 15 working days (of the date of this summary) to discuss outstanding work at the property to include the issues of cavity wall, chimney stack and the guttering
- b) provide Mrs X with an action plan detailing what work would be carried out and dates for completion of the proposed works. The action plan to be completed within 15 working days of the meeting at her home address.

### Cardiff Council - Repairs and maintenance

Case reference 201507174 – Report issued in April 2016

Mrs A complained that Cardiff Council (“the Council”) failed to carry out repair works to a leaking roof which has resulted in a change of living conditions.

On receiving the complaint the Ombudsman contacted the Council and it confirmed that there had been some breakdown in communication. It was agreed that the Council would:

- a) provide Mrs A with a written apology for the delays caused and a summary of the actions agreed
- b) offer Mrs A a payment of £150 for the delay in carrying out the repair work and time and trouble in raising a complaint.

It was also noted that the Council made a recent visit to the property and would attempt to carry out the repair work within 28 days of the visit.

## Wales and West Housing Association - Repairs and maintenance

Case reference 201506860 - Report issued in April 2016

Mr T complained to the Ombudsman because he said that Wales and West Housing Association ("the Housing Association") had not responded to his request for an adapted bathroom to be reinstated to a family bathroom. Mr T said he then complained and received no response from WWHHA.

The Ombudsman contacted the Housing Association for further information which agreed to the following:

- a) to arrange a meeting with Mr T to discuss concerns
- b) to reinstate a family bathroom as agreed to the meeting, and
- c) to complete the work within two weeks.

## Bron Afon Community Housing Ltd - Repairs and maintenance

Case reference 201505257 - Report issued in April 2016

Mrs A complained that Bron Afon Community Housing Ltd ("the Housing Association") had failed to adequately respond to damp problems in a flat owned by her and her brother under a leasehold agreement. She also complained that it had failed to deal with her complaint in a timely manner.

The Ombudsman found that the damp problem did not fall within the definition of an emergency repair and that part of the damp problem was within the flat, which was the owner's responsibility. This part of the complaint was not upheld.

However, the Housing Association had not resolved the complaint at stage 2 of its procedure. The Ombudsman recommended that the Housing Association:

- a) contact Mrs A and arrange a local resolution meeting with her
- b) write a letter of apology for the delay in dealing with her complaint, and
- c) offer £150 ex gratia payment for time and trouble taken.

## Tai Calon - Repairs and maintenance

Case reference 201506471 - Report issued in April 2016

Mr T complained to the Ombudsman following the fitting of a waste pipe in his property which resulted in water leaks that damaged his property. Mr T highlighted concerns with the level of customer service and the standard of complaint handling when raising his concerns directly with Tai Calon ("the Housing Association").

The Ombudsman found that the cause of the damage was a civil matter of liability and not one which the Ombudsman could make a judgement on. However, with regard to the handling of the complaint, the Ombudsman found that although the Housing Association's actions were reasonable overall, their actions did not adequately meet the Ombudsman's expectations of a body to maintain a customer-focused approach to complaint resolution, particularly in terms of managing customer's expectations,

and dealing with complaints in a flexible, sensitive and helpful manner. The Housing Association agreed to:

- a) provide a further, more fulsome apology to Mr T, and
- b) offer a small financial token of £50 to reinforce the sincerity of that apology.

## Merthyr Valleys Homes - Repairs and maintenance

### Case reference 201507097 - Report issued in May 2016

Mrs X complained on behalf of her father (Mr Y) of a failure to carry out repair work to his property which had been caused by a building company contracted by Merthyr Valley Homes ("the Housing Association") carrying out work to his neighbour's property. As a result, Mr Y suffered distress as he had to take time off work to speak to the Housing Association as they did not respond to his emails.

Having considered the complaint and the information provided, the Ombudsman formed the view that a detailed investigation was not required as repairs had already been carried and there was no evidence of any leaks or damage to Mr Y's property. Assurance was given by the Housing Association that if any defects become apparent in time they will be rectified.

The Housing Association agreed to undertake the following in settlement of the complaint within 20 working days of the issue date of the Ombudsman's report:

- a) write a letter of apology to Mr Y for the delays in dealing with the complaint which fell outside of their complaints guidance
- b) offer an ex gratia payment of £50 to reflect the time and trouble taken by the complainant in making the complaint and for the distress caused to Mr Y.

## Merthyr Valleys Homes - Repairs and maintenance

### Case reference 201600494 - Report issued in May 2016

Mrs X complained on 26 February 2016 that Merthyr Valley Homes ("the Housing Association") had not dealt with a matter of water penetration and damp at her home promptly or to a satisfactory standard. A deadline was agreed for completion of the works by 15 April and the Ombudsman's file was closed.

On 25 April Mrs X again contacted the Ombudsman as the work to her property had not been completed. On receipt of this complaint, the Ombudsman contacted the Housing Association for further information and an update. After considering the information provided, the Ombudsman did not consider a full investigation was required as the Housing Association had in the meantime taken steps to remedy the issues and a plan was in place to complete the outstanding works which the complainant was satisfied with. The Housing Association had also reimbursed the complainant the cost of replacing water damaged kitchen blinds.

The Housing Association agreed to undertake the following action within 20 working days of the date of this summary in settlement of the complaint:

- a) write a letter of apology to the complainant for the delays in dealing with the complaint
- b) offer an ex gratia payment of £50 to reflect the time and trouble taken by the complainant in making the complaint and the stress caused to her and her family.

## Powys County Council – Repairs and maintenance

### Case Reference 201600373 – Report issued in May 2016

Mr C complained that Powys County Council (“the Council”) had failed to respond and deal adequately with damp and water ingress problems at his home. He also complained that the Council’s communications with him were poor.

The Ombudsman recommended that the Council:

- (a) contact him within 5 working days of my request.
- (b) arrange a site meeting with him within 15 working days of contacting him.
- (c) provide an action plan of agreed works within 10 working days of the site meeting.

The Council had already carried out recommendations(a) and (b)and agreed with all recommendations.

## Ceredigion County Council – Repairs and Maintenance

### Case reference 201506924 - Report issued in May 2016

Miss A complained that Ceredigion County Council’s (“the Council”) contractor caused damage to her property when it carried out improvement works, funded by a Disabled Facilities Grant. The Council had agreed to undertake further work to repair the damage; however, it was waiting for confirmation from Miss A before proceeding.

The Council agreed to arrange a meeting with Miss A and her surveyor within 20 working days, to discuss the outstanding required work and agree a way forward. The Ombudsman considered that the action which the Council said it would take was reasonable and would resolve Miss A’s complaint.

## Carmarthenshire County Council - Repairs and maintenance

### Case reference 201506999 - Report issued in June 2016

Mrs X, who is elderly and disabled, complained about several repair issues regarding the condition of her property when her tenancy began in May 2015. Her primary complaint was regarding the failure of the central heating system and the distress and inconvenience that this caused her.

The repair aspects of her complaint were not considered suitable for investigation. However the central heating element of her complaint was considered suitable for settlement with Carmarthenshire County Council (“the Council”).

The Council agreed to the Ombudsman’s recommendation to make a redress payment to Mrs X for £650.

## Carmarthenshire County Council - Repairs and maintenance

### Case reference 201601096 - Report issued in June 2016

Mr D complained that Carmarthenshire County Council ("the Council") had failed to respond effectively in order to repair a defective central heating system in his home. This caused him to be without any heat in his home between October 2015 and February 2016.

The Council had apologised in a letter to the complainant, but, it was felt that it had not sufficiently addressed the hardship experienced by him during the period concerned. The Ombudsman made the following recommendations which the Council agreed to undertake:

- a) write a further letter confirming its apology previously included in its response letter to Mr D, dated 18 April 2016
- b) offer an ex gratia payment of £280 in recognition of the hardship suffered by Mr D during the winter of 2015.

## RCT Homes - Repairs and maintenance

### Case reference 201600987 - Report issued in June 2016

Ms B complained to the Ombudsman about the condition of her kitchen which was old and in a state of disrepair. Ms B said that an engineer had to repair a unit door which had fallen off. Ms B complained that when she asked for a replacement kitchen, she was informed by RCT Homes ("the Housing Association") that the kitchen upgrade was scheduled for the financial year 2016/17.

Following a discussion, the Housing Association agreed to:

- a) Arrange for a surveyor to carry out a site visit to inspect the condition of the kitchen
- b) look into expediting the kitchen upgrade should this be the recommendation of the surveyor.

## Planning and Building Control

### UPHELD

#### Flintshire County Council – Handling of planning application (other)

Case reference 201408787 - Report issued in May 2016

Mr and Mrs X complained about how Flintshire County Council (“the Council”) approved a planning application for a development which included the construction of a dwelling whose flank wall was significantly closer to the front of their property than the minimum distance advised by the Council’s own supplementary planning guidance dealing with space around dwellings.

The investigation found maladministration when a planning officer misinformed the local member that the application was in accordance with the guidance, when it clearly wasn’t. The local member was considering whether the application should be called in to be determined by the planning committee.

The application was instead determined by the same planning officer under delegated powers.

The investigation found that the complainants had been caused an injustice in that there was significant uncertainty as to whether the application would have been approved if the maladministration had not occurred and the application had been determined by the planning committee.

The complaint was therefore upheld. The Ombudsman recommended that the Council:

- a) apologise for the failings found
- b) make a payment of £3,000 to reflect the uncertainty referred to above and the time and trouble expended by the complainants pursuing their complaint, and
- c) review the wording of the relevant guidance to ensure that they were not overly prescriptive and that they were consistent with their advisory status.

The Council agreed to implement the recommendations.

#### Monmouthshire County Council - Other planning matters

Case Reference 201501740 – Report issued in May 2016

Mr C was dissatisfied with the failure by the Monmouthshire County Council’s (“the Council”) Local Planning Authority (“LPA”) to properly carry out enforcement action against his neighbour Mr X. Since 2013, Mr X had repeatedly breached a planning condition to relocate a horse manure waste pile in sight of Mr C’s property. A previous Council investigation, completed in September 2014, had identified failings including delays in the LPA using its enforcement powers and had made recommendations to prevent this happening again.

The Ombudsman’s investigation found evidence of unreasonable delay in the LPA using its enforcement powers pre September 2014. However, poor record keeping, coupled with administrative failings/ mishaps, meant the Ombudsman could not preclude the possibility that after this date there continued

to be instances when Mr C's case had been allowed to drift for longer than it should. The Ombudsman therefore upheld Mr C's complaint.

The Ombudsman's recommendations included the Council apologising to Mr C, making a payment of £750 and learning lessons.

## Pembrokeshire County Council - Handling of planning application (other)

Case reference 201600690 – Report issued in June 2016

Mr W complained that Pembrokeshire County Council ("the Council") took two years to determine the outcome of his planning application, and that when he complained the Council "blamed" him because he had not contacted them to establish the progress of his case.

The Ombudsman found that the delays in determining the application were excessive, and that the tone of the initial complaint response could be interpreted as placing the onus on Mr W to ensure his application progressed in a timely manner.

Upon being informed of these concerns, the Council immediately issued a sincere apology to Mr W and demonstrated how the systems and processes of the department were already improved. However, to compensate him for his personal injustice, the Ombudsman recommended that the Council offer Mr W £250 in redress.

## Ceredigion County Council – Unauthorised development

Case Reference 201501463 – Report issued in June 2016

Mr A complained about Ceredigion County Council's ("the Council") handling of his concerns about a wind turbine erected next to his home. He complained about the decision to approve the application and about delays in addressing his complaints of noise nuisance and a breach of development control.

The Ombudsman partly upheld the complaint, having found some procedural and administrative errors in the Council's handling of the application and in its response to Mr A's concerns. The Ombudsman recommended that, in recognition of the identified failings, the Council should apologise and make a payment of £500 to Mr A, as well as reviewing and auditing its planning procedures.

## NOT UPHELD

## Denbighshire County Council - Handling of planning application (failure to notify those affected)

Case reference 201408558 – report issued in April 2016

Mr D complained that Denbighshire County Council ("the Council") did not properly consult him on an application to build a housing development on land adjacent to his home. He was also concerned that the effect on his amenity was not taken into account.

At the time the planning application was being considered, Mr D's house was under construction and unoccupied, although the roof and chimney can be seen from photographs taken during the site visit.

In relation to the consultation, the Council had met the statutory requirements for the type of application

by posting a site notice and publishing a notice in the local paper. As Mr D's house was still being built and was unoccupied, there was no address to send a notification letter to, and a search of the Council's files to find out Mr D's contact details would have been disproportionate.

In relation to the effect on Mr D's amenity, the Ombudsman found there was maladministration by the Council as it was not considered in the planning officer's appraisal of the application. However, this would not have affected the decision as the development was in accordance with the Council's planning policies and consequently there was no injustice to Mr D. Therefore the Ombudsman did not uphold the complaints.

## EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

### Ceredigion County Council – Other planning matters

#### Case reference 201505565 - Report issued in May 2016

Mr X complained about his dealings with Ceredigion County Council's ("the Council") planning department. In particular, he said that the department had given him contradictory advice about whether planning permission would be required for the construction of a wall outside his property, which was a listed building.

The Ombudsman found that the advice did not appear to be wrong; rather it was unclear because whether planning permission would be required depended on the exact plans, size and location of the wall. The Council agreed to hold a site meeting at the property with relevant staff to discuss the issue with Mr X in more detail. The Ombudsman's view was that this was an acceptable way forward and further investigation was not merited.



## Social services - Adult

### UPHELD

Conwy County Borough Council, Gwynedd Council and CSSIW

Case Numbers: 201500280/201500281/201500282

Mrs A and Mrs B complained about the investigation of the circumstances surrounding the death of their mother, Mrs C, after a stay in a care home. They said that:

- a) Conwy County Borough Council (in whose area the home was situated) did not fully investigate Mrs C's death
- b) Gwynedd Council (who had arranged Mrs C's placement in the home) failed to ensure a care plan was in place for her and did not get involved in the investigation
- c) CSSIW did not fully investigate their complaint.

The Ombudsman found failings on the part of all three bodies:

- a) failings in Conwy's handling of the POVA process, in its communication with Mrs C's family and in the way in which their complaint was handled
- b) failings in Gwynedd's assessment of Mrs C's needs, in its review of her placement in the care home and in its engagement with the POVA process conducted by Conwy, and
- c) failings in CSSIW's engagement in the POVA process and in its inspection of the care home.

The Ombudsman recommended that all three bodies:

- a) apologise to Mrs A and Mrs B, and
- b) put in place training and process reviews to prevent a re-occurrence of the failings identified.

He also recommended that Conwy make a payment of £250 to Mrs A and Mrs B in recognition of their time and trouble in pursuing their complaint.

**Cardiff Council - Services for vulnerable adults**

Case Reference 201500631 Report issued in May 2016

Mrs A complained about Cardiff Council's ("the Council") Adult Social Services Department and its failure to provide her with sufficient support after she became involved in her mother's care. Her concerns included the Council's failure to assess her mother's needs and safety as a vulnerable adult.

Mrs A also complained about the Council's poor communication and handling of her complaint.

The Ombudsman's investigation found that, although the Council failed to review Mrs A's mother's needs, there were safeguards in place to alert the Council should those needs change and a reassessment become necessary. He was also satisfied that the Council had considered Mrs A's concerns about her mother's safety as a vulnerable adult and that the protection of vulnerable adult process had been followed correctly. The Ombudsman did not uphold this aspect of Mrs A's complaint.

The investigation found, in terms of Mrs A's needs as a carer, that whilst the Council did offer support, these options proved impractical as Mrs A lived in another city. The Ombudsman was of the view that, had the Council, carried out a carer's assessment with Mrs A, as it was supposed to do, it would have helped identify support more tailored to meet her needs. He therefore found that the Council's inaction amounted to maladministration and upheld this aspect of Mrs A's complaint. The Ombudsman recommended that the Council apologise for this shortcoming and pay Mrs A the sum of £200.

## EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

**Flintshire County Council - Services for vulnerable adults (eg with learning difficulties, or with mental health issues)**

**Case reference 201506287 - Report issued in April 2016**

Mr W complained about a decision taken by Flintshire County Council ("the Council") as part of a review of its Learning Disability Services. In particular Mr W was concerned that the Council had identified the supported living accommodation where his son lived as part of its Move On programme. Mr W said that the Council failed to appropriately capture his son's care needs as part of its decision making process.

The Council agreed to:

- a) complete an independent reassessment of Mr W's son's needs, and
- b) reapply the outcomes of the new assessment to the criteria summary sheet used as part of its identification and selection process.

**Newport City Council - Services for People with a disability inc DFGs**

**Case reference 201506518 - Report issued in April 2016**

Mr A complained to Newport City Council ("the Council") on 14 December 2015 about works carried out to his property under a Disabled Facilities Grant. Specifically, Mr A complained about the new route of hot and cold supply installation for the bathroom adaptation. Mr A said he was unaware that the pipe work would be exposed, which in his view ruined the bathroom. Mr A complained to the Ombudsman that the Council failed to provide a response to his complaint.

Following consideration of the complaint, the Ombudsman contacted the Council to discuss Mr A's concerns. The Council explained that Mr A's complaint was sent to it as a recorded delivery but it was issued to the incorrect department for dealing with the complaint. Following a telephone conversation between Mr A and the Council on 9 March 2016, the Council became aware of the circumstances of Mr A's complaint, and it agreed to provide him with a full written response.

The Ombudsman noted that the Council responded to the complaint on 6 April 2016.

## Conwy County Borough Council – Services for vulnerable people

Case reference 201507045 Report issued in May 2016

Mrs A complained to the Ombudsman on behalf of her son, Mr B, about Conwy County Borough Council (“the Council”) and its administration of his residential care placement.

Mrs A alleged that her son had been assaulted by another resident at the private care home on five occasions and said that the Council had not done enough to protect him from harm. Although Mrs A had asked the care home to investigate her concerns, the matter was not considered as a formal complaint and it had not been brought to the Council’s attention.

On receipt of the complaint, the Ombudsman contacted the Council and it agreed to appoint an independent investigator to consider the matter in accordance with stage 2 of the statutory social services complaints procedure.

## Newport City Council – Services for older people

Case reference 201600779 - Report issued in June 2016

Mr G complained that he had not received a response to a complaint he made to the Finance and Social Services Department of Newport City Council (“the Council”) in 2015. Mr G raised concerns regarding the handling of his complaint because he had been advised that he would receive a response but the Council kept missing their target dates to do so.

The Ombudsman found that the Council had repeatedly promised action and then failed to provide a response to the complaint. Mr G had to wait seven months to receive a response. The Ombudsman considered this to be excessive, and recommended that the Council:

- a) apologise to Mr G for the delay
- b) offer £100 as a token of apology
- c) expedite the response.

## Caerphilly County Borough Council - Other

Case reference 201600821 - Report issued in June 2016

Mr X and Ms X made a complaint to Caerphilly County Borough Council (“the Council”) on 7 February 2016. They received an acknowledgement on 12 February but no further response following this. The Ombudsman recommended the following settlement, which the Council agreed to undertake:

- a) to send Mr X and Ms X a response to their complaint by 20 June 2016
- b) to make a redress payment of £50 to them to reflect the time and trouble taken pursuing this complaint with the Council and this office.

## Vale of Glamorgan Council - Services for People with a disability inc DFGs

Case Reference 201501219 – Report issued in June 2016

Ms A complained that the Vale of Glamorgan Council (“the Council”) had not addressed her concerns,

about the domestic and personal care provided for her by three domiciliary care agencies ("the Agencies"), fully and robustly. She said that the Council's response to these concerns had been 'dismissive'. She also maintained that the Council had not discussed introducing double-handed visits, with her, beforehand and suggested that this was unreasonable.

The Ombudsman considered that the Council had not dealt with all of Ms A's concerns, about the care given to her by the Agencies, properly. He also decided that its communication with Ms A, about the double-handed visits, had been lacking. He concluded that it would be appropriate to try settling Ms A's complaint. The Council subsequently agreed to:

- (a) write to Ms A to apologise for the service failings identified and to address her Agency-related concerns.
- (b) share its letter, with the Ombudsman, before sending it to Ms A, in an effort to ensure that it satisfies the brief given.
- (c) - discuss Ms A's complaint and its resolution with the Care and Social Services Inspectorate Wales
- (d) pay Ms A a nominal sum of £250 for the service failings identified
- (e) pay Ms A a nominal sum of £50 in recognition of the inconvenience, associated with pursuing her formal complaint, that she had experienced
- (f) specify and highlight, within its 'Provider Performance Monitoring Protocol' ("the Protocol"), that concerns about quality standards include missed calls, unpunctual calls and those pertaining to a significant number of different carers caring for one service user
- (g) share its revised Protocol with Ms A.

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

## Social services - children

### UPHELD

#### Torfaen County Borough Council - Other

#### Case reference 201600101 - Report issued in April 2016

Mr W complained that the support he received from Torfaen County Borough Council's ("the Council") Families First Service was below standard, which resulted in his son missing out on vital support within his school. Mr W also said that he was not kept informed and found the situation distressing because of the impact on his son.

The investigation found that Mr W had not yet complained to the Council, but that this was a failure of the complaint handling process which failed to advise Mr W correctly on how to escalate his complaint.

The Council agreed to undertake the following actions in settlement of the complaint:

- (a) apologise to Mr W
- (b) complete a full investigation of the original complaint and provide a Stage 2 response, and
- (c) offer a sum of £25 redress for the time and trouble to Mr W.

### EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

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

#### Case reference 201600259 - Report issued in June 2016

Mrs A was unhappy with Torfaen County Borough Council's ("the Council") final response to her complaint about a child protection investigation involving her grandson. In particular, she was dissatisfied with the Council's written response to the Independent Investigator's report where it said, "I hope that the information contained within [the] report reassures you that the Local Authority did consider points 3.5.3 of the 2008 All Wales Child Protection Procedures." Mrs A felt that this statement was not supported by the Independent Investigator's findings.

On receipt of the complaint, the Ombudsman wrote to the Council and it agreed to write to Mrs A to acknowledge that, without the appropriate records having been made, it was not in a position to reassure her that everything was done in accordance with the All Wales Child Protection Procedures.

## Various - other

### EARLY RESOLUTIONS AND VOLUNTARY SETTLEMENTS

#### Vale of Glamorgan Council – Economic development

Case Number: 201506799 – Report issued in May 2016

Ms N, an owner occupier, complained about the way a renewal area group repair scheme (“the scheme”) had been overseen by the Vale of Glamorgan Council (“the Council”). The scheme had been ongoing for many years, was problematic, and Ms N had complained about defective works undertaken by contractors. She also complained about how the Council had handled her complaints. An independent survey commissioned by the Council had identified a number of issues. The Council had subsequently agreed it would rectify the work at its cost. The Council also confirmed that it would issue a guarantee for the works to replace the void guarantees already provided by the contractors.

In light of limitations on his jurisdiction, and that many of the issues were now historical, the Ombudsman resolved to settle the complaint. The Council agreed to implement the following terms of settlement:

- a) complete the outstanding works as soon as practicable
- b) issue written confirmation of its guaranteeing the work on completion for a 10 year period (so such evidence could be placed with Ms N’s title deeds)
- c) offer a further written apology and redress of £300 for its complaint handling failures (payable within one month)
- d) agree to reimburse Ms N for any out of pocket losses as evidenced by receipts (to be provided to the Council within three months)
- e) pay Ms N the sum of £1,500 redress for her injustice arising from the protracted nature of the works and inconvenience (payable within one month).

#### Vale of Glamorgan Council – Economic development

Case Reference 201506800 - Report issued in May 2016

Mr D, an owner occupier, complained about the way a renewal area group repair scheme (“the scheme”) had been overseen by the Vale of Glamorgan Council (“the Council”). The scheme had been ongoing for many years, was problematic, and Mr D had complained about defective works undertaken by contractors. He also complained about how the Council had handled his complaints. An independent survey commissioned by the Council had identified a number of issues. The Council had subsequently agreed it would rectify the work at its cost. The Council also confirmed that it would issue a guarantee for the works to replace the void guarantees already provided by the contractors.

In light of limitations on his jurisdiction, and that many of the issues were now historical, the Ombudsman resolved to settle the complaint. The Council agreed to implement the following terms of

settlement:

- a) complete the outstanding works as soon as practicable
- b) issue written confirmation of its guaranteeing the work on completion for a 10 year period (so such evidence could be placed with Mr D's title deeds)
- c) offer a further written apology and redress of £300 for its complaint handling failures (payable within one month)
- d) agree to reimburse Mr D for any out of pocket losses as evidenced by receipts (to be provided to the Council within three months)
- e) the sum of £1,500 redress payable for his injustice and inconvenience – such sum was off-set against the means tested financial contribution payable by Mr D.

### **Betsi Cadwaladr University Health Board - Poor/No communication or failure to provide information Case Reference 201600449 – Report issued in May 2016**

Mr G complained that Betsi Cadwaladr University Health Board (“the Health Board”) had failed to provide a response to his complaint within a reasonable time frame. He said that he had written on 15 December 2015 to lodge a complaint and in April 2016 had still not received a substantive response.

The investigation found that the Health Board had written in December, January and February to indicate that the investigation was ongoing but the Health Board took over 4 months to provide its response. The Ombudsman considered that the initial complaint matter was not overly complex, and therefore this delay was excessive.

The Ombudsman therefore recommended that the Health Board undertake to:

- (a) provide a full apology and explanation for the delay
- (b) expedite the full and final response within 3 weeks.

### **Isle of Anglesey County Council – Other miscellaneous Case reference 201506705 - Report issued in June 2016**

Mr G complained that the Isle of Anglesey County Council (“the Council”) had delayed or failed to properly follow procurement due process in relation to his wife, Mrs G's, tender for the purchase of a Council business asset sale. It had initially indicated that Mrs G's tender had been successful. After some months, the Council withdrew from the sale. Throughout Mrs G was legally represented and Mr G complained that the Council had by its actions put his wife and the family to unnecessary expense, acted unfairly in withdrawing, and had not given him or Mrs G, when they requested through her solicitor, adequate reasons for its decision.

On examining the documents, the Ombudsman found that the Council had properly followed due process. When there were changes to Mrs G's original accepted tender, the Council was entitled (still at pre contract stage), under procurement law, to seek certain further information to satisfy itself. This was particularly relevant when Mrs G's revised position meant she was offering a reduced price. So whilst it was not for him to question the Council's decision, the Ombudsman felt there were plausible reasons for

it.

Nevertheless, the Council failed to acknowledge or respond to Mrs G's solicitor's written request for further clarity about its decision (albeit it had advanced some reasons). In responding to Mr G's complaint, the Council sought to rely on a document it said entitled it to abandon the process for any reason. However, when asked by the Ombudsman it was unable to produce it. The Ombudsman found that the Council had failed to respond to a legitimate written request. It had further misinformed Mr G when he complained. The Ombudsman made the following recommendations, all of which the Council agreed to implement within one month:

- a) provide a written apology to Mr G (and through the letter to Mrs G) for failing to respond to her solicitor's letter and for the subsequent misinformation in its complaints response to Mr G
- b) in recognition of these failings it should offer Mr & Mrs G redress of £400 for their time and trouble in pursuing the complaint.

**Rhondda Cynon Taf County Borough Council – Other miscellaneous**  
**Case reference 201601424 - Report issued in June 2016**

Mr L complained that Trading Standards investigated his consumer dispute and obtained a prosecution against the trader, but failed to make an application for compensation on your behalf when the matter was taken to Court.

The Ombudsman found that the relevant documentation to Mr L's Compensation Order was misplaced by the department, resulting in a failure to submit his claim for compensation and ultimately Mr L was left with no other choice but to undertake Civil Court proceedings himself.

Rhondda Cynon Taf County Borough Council ("the Council") agreed to implement the following recommendations:

- a) provide a fulsome apology to Mr L
- b) offer £250 redress for inconvenience, time and trouble
- c) offer Mr L a further £115 to cover his costs to apply independently to the Civil Court.

**Cardiff Council – Other miscellaneous**  
**Case reference 201600298 - Report issued in June 2016**

Ms A complained that Cardiff Council ("the Council") failed to collect her recycling bags. Ms A previously raised a concern with the Council and it responded in January 2016 apologising and given assurances that the issues had been dealt with. Since that time Ms A had experienced further problems with the service.

The Council agreed to:

- a) provide a full explanation of what action will now be taken to ensure that the issues do no reoccur
- b) offer Ms A £100 for the time and trouble.



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

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